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ABSTRACT

This guide offers counselors and special education and classroom teachers assistance in counseling handicapped children. Major articles focus on counseling children who are mentally retarded, emotionally, visually and hearing impaired, learning disabled, and gifted. Additional information is provided on: (1) sexual fulfillment for the handicapped: (2) prescriptive interventions for exceptional children: and (3) a model of consultation for exceptional children and youth. (BMW)

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COUNSELING EXCEPTIONAL PEOPLE

Edited By
Libby Benjamin and Garry R. Walz

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FOREWORD

The impetus for this book came from our family of ERIC users. "What do you have that can help me counsel handicapped kids?" "What can I do to relate more closely and be of more assistance to my counselees with learning disabilities?" "Are there special techniques to use in guiding the gifted?" Questions like these from counselors all over the country, starting as a trickle and then beginning to inundate us, made us realize that a real need was developing in regard to the counseling of special subgroups. We started looking for causes.

Having experienced counselor education programs ourselves, first as students, and then for many years as teachers, we knew that they are so stocked with philosophy, history, management, methods, and practicum that little attention is ever given to the development of skills for counseling unique populations. We were also quite aware of the tremendous impact of Public Law 94-142, the "Education for All Handicapped Children Act," on the education of both handicapped and nonhandicapped students. PL 94-142 mandates that all handicapped children receive appropriate, free education. The law states, too, that the education of the exceptional child is not the domain solely of special education, but also must involve parents and professionals from related education and health fields. In addition, education for handicapped children must be conducted in the "least restrictive environment," which means that these students must be integrated into the mainstream of the educational milieu. And the law has teeth in it. States must comply with the provisions of this act or risk withdrawal of all federal funds.

The reasons for the questions became obvious. First of all, it was clear that mainstreaming is taking place and that counselors, as "professionals from a related educational field," were encountering more exceptional students as clients. Second, the dramatic increase in the kind of requests we were getting meant that counselors were taking their new responsibilities seriously indeed, and were searching for strategies that would be of real use to them. Our Clearinghouse staff put themselves to the task of providing substantive help.

We did a computer search of ERIC and came up with quite a number of resources, 155 to be exact, most of them targeted to very special populations, a lot of them describing helpful teaching strategies, a few discussing preventive programs, and a very small number dealing with what counselors can or are or should be doing. We even created a Searchlight Plus on the topic, "Counseling the Exceptional: Handicapped and Gifted." That's a special publication that contains not only the citations gleaned from ERIC through a computer search on a selected topic (the usual contents of our normal Searchlights) but also a plus: several pages of text that analyze the documents in the search--trends, developments, implications for counselors.

Somehow, though, that didn't seem to be enough. Our readers still had to pore through the microfiche and dig out the gems that would be of practical help, a time-consuming task that requires a lot of persistence and a high level of motivation. Not that counselors don't possess those qualities--they just have too many presses in their already tight schedules. We then proposed, in our ERIC/CAPS plan for 1979, to create a publication that would bring together what had been learned about counseling exceptional people into one tidy package.

Our first vision was of a kind of guide or handbook that would teach counselors some special approaches or techniques for working with all kinds of exceptional people, touching broadly but lightly on a number of types of exceptionality. As we delved deeper into the field, however, we began to see that the needs of the visually impaired, for example, differ in great respect from the needs of the mentally retarded or the hard-of-hearing, and that what was appropriate for one group would not be for another. Each area of exceptionality needed more depthful treatment. So, we expanded our vision.

First, we identified some areas of exceptionality that occur frequently enough that most counselors will at some time count such persons among their clients. Then we started the search for authors, who, in turn, suggested other areas that should be included. This book is the result.

The first six chapters deal with counseling techniques that are appropriate for six different kinds of exceptionality, including giftedness. Although the focus is primarily on the school setting, many of the approaches described are suitable for adults as well. These are followed by a chapter that describes ways of helping handicapped individuals to achieve more rewarding living through fulfillment of their sexual needs. Chapter eight offers 106 extremely practical suggestions for counselors covering 14 problem areas commonly encountered in educational settings. The final chapter presents a developmental model of consultation that will be useful in providing counselors with a structure for offering consultant services to the many individuals who are involved in the education of exceptional persons.

That the idea for the book became a reality is due to the efforts of many people. First, of course, of the authors. Each of them is a recognized authority in a particular field, and most have devoted and are devoting their professional lives to improving services for people who need special help. Then of our staff--Beverly Pritchett, who designed the search that we sent to each author; Pat Wisner, our skillful typist; Penny Schreiber, our publications coordinator, who also edited two of the chapters; the several staff members who proofed the manuscript before it went off to the printer. All of these persons performed their tasks willingly and well.

It was a most rewarding experience to develop this manuscript. Especially was it enjoyable to work with the authors. Probably one of the most gratifying aspects of our communications was their response to the project. If we were excited about doing it, they seemed to be even more so; and we all agreed that it was a book that was important, timely, and needed. We hope readers will find it to be so as well.

LB and GRW

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1 COUNSELING THE MENTALLY RETARDED

Harold Rubin

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COUNSELING THE MENTALLY RETARDED

Harold Rubin

This paper examines the historical view that counseling the mentally retarded is a nonprofitable expenditure of effort, and reports the emergence of more positive attitudes toward such counseling. The author discusses the needs of the retarded and presents a rationale for counseling this population. The "educable retarded" are viewed as a high priority group for counseling. Counselor characteristics and role function are seen as critical determinants of counseling outcomes. The problems of counseling school-age and adult retardates are treated separately. Also discussed are the importance of parental and family role functions and the benefits of group approaches. The paper concludes with an evaluation of the impact of current legislation, including the concepts of mainstreaming and normalization, and provides a hopeful look to the future for the development of counselors who would act as "transitional specialists."

Introduction

Though for many years counseling or psychotherapeutic procedures have been fully accepted in the treatment armamentarium of mental illness, they have not received the same recognition as an effective treatment modality for the problems of the mentally retarded. Only recently has specific attention been given to utilizing accepted counseling procedures in the field of mental retardation.

There are several reasons for the delay in using counseling approaches with the retarded, the major obstacle being the belief that these individuals are unable to profit from such treatments (Sarason, 1953). In discussing this erroneous assumption, Hutt and Gibby (1965) refer to Sarason's statement that:

> *the retarded child cannot tolerate strong emotional states; he cannot view the behavior of other individuals in an objective manner; he has difficulty in relating to other people; he cannot see the results of his maladaptive behavior.* (p. 367)

They agree with Sarason that "the pessimism expressed concerning counseling with retarded children has been based on theoretical deductions rather than on research considerations" (p. 367).

Two important schools of psychotherapy, psychoanalysis and client-centered therapy (Fenichel, 1945; Hutt & Gibby, 1965), have taken a negative view of the use of their techniques with the retarded. In discussing contradictions for psychoanalytic therapy, Fenichel included "feeblemindedness." Browning (1974) refers to such early beliefs in his annotated bibliography. Though many subscribed to this view, some did not. Chidester and Menninger (1936) reported an increase in I.Q. of 28 points following four years of psychoanalytic treatment. Rank (1949) used psychoanalytic techniques to treat children who were considered psychotic or feebleminded, to restore a more favorable acceptance of self caused by earlier emotional deprivation due to a narcissistic, immature mother. Rogers (1942), in discussing criteria for counseling, stated that the individual to be counseled must have at least dull normal or higher intelligence--which he regards as essential for coping with life situations. Sternlicht (1978) regards the lack of a systematic and comprehensive theory dealing with psychotherapy as one of the critical issues in this field. He believes that though we now have effective treatment methods for the retarded, we lack an adequate personality theory of retardation.

Some also had the mistaken belief that the retarded do not have the verbal skills necessary for psychotherapeutic interventions (Abel, 1953). Sarason (1959) states,

> *When one considers that language is almost the sole means of communication between therapist and patient and that the defective individual has inordinate difficulty in using and comprehending verbal generalizations, it is not surprising that the usual psychotherapeutic interview has been viewed as unfeasible with such individuals.* (p. 263)

Sarason also believes that practical issues are partly responsible for the paucity of research in this area. He points to the demand for and scarcity of trained counselors and the amount of time involved in counseling, and believes that this has caused clinicians to work with those who give the most promise for positive results. Thus, the retarded would constitute a low priority with trained counselors. This same sentiment is shared by Abel (1953), who believes that the unwillingness of some counselors to work with the mentally retarded is their belief that

> *it is too time consuming with little to show as a result...it is not worth the time and effort to treat...a retarded who may only reach fourth grade in academic achievement and do simple labor in adult life.* (p. 107)

These attitudes reflect the tendency in the past to view the mentally retarded as a homogeneous group at the lower end of a normal intelligence curve, characterized by poor communication skills, poor social and self-help skills, and almost nonexistent academic and vocational potentials. Treatment or rehabilitative procedures have focused largely on the development of self-help and communication skills sufficiently adequate to enable the individual to live comfortably in either a protected home environment or in an institutional setting. Little attention was given to the fact that this characterization represented only 5% of the total population of mentally retarded individuals, and that at least 89% or more possessed relatively adequate verbal skills and other potentialities approximating or overlapping those of nonretarded individuals (Baroff, 1974).

The term "mental retardation" actually designates a hierarchy of retardation of mild, moderate, severe, and profound. It is the mildly retarded individuals (I.Q. 55-70) and those at the upper levels of the moderately retarded group (I.Q. 40-54) that are the focus of this paper. These are the individuals who are mostly referred to as "educable mentally retarded." They either already have developed, or have the potential for developing, adequate communication skills and are capable of achieving a satisfactory social and vocational adjustment. The emotional problems of the mentally retarded are not idiosyncratic to their population. However, because of their lower intellectual capacities they may have even more difficulty than the nonretarded in adjusting to personal and social problems. In their discussion on the problems of adjustment of the mentally retarded child, Hutt and Gibby state,

> *the mentally retarded child shows no behavioral reactions that are not shown by the child of normal intellectual capacities. The essential difference between the two is that the mentally retarded child is more prone to show maladaptive behavioral reactions, and that such behavior tends to persist over a much longer period of time than that of the more normal child.* (p. 195)

One other factor which served to limit the use of counseling techniques with the retarded was the belief that mental retardation was due to brain damage, and that since this damage was irreversible, there was nothing that counseling could accomplish that would change this condition. A survey of practices in counseling the retarded conducted by Woody and Billy (1966) listed reasons why they were not counseled more. These researchers found that lack of adequate time was often reported by respondents as the reason for limiting their services to the retarded and that occasionally these services were not compatible with the philosophy of the particular work setting. This latter disturbing finding probably reflected an administrative attitude (for whatever reason) that counseling with the mentally retarded was of no value.

Despite the negative opinion held for many years that counseling with the mentally retarded was of little or no value, there were some who refused to accept this view. These individuals are well documented in Browning (1974); however, much of their work has been done in institutional settings. Thorne (1948), in reporting on the value of using psychotherapy with the mentally retarded, states, "Contrary to established attitudes in the child guidance movement, counseling and psychotherapy with the mental defectives is both possible and profitable" (p. 263). Also on the more positive side was the finding by Woody and Billy (1966) that counseling was often or occasionally of value to the mentally retarded in each of ten selected problem areas of retardation. These areas were institutional adaptation, motivation for learning, peer group associations, familial relationships, control of unacceptable behavior, authority figure resolution, return to the home, personality modification, return to the community in an active role, and improving employability. Only in the area titled "Improvement of Measurement in Psychodiagnostics" was there a question concerning the value of counseling, and even this was rated "undecided." Perhaps one additional finding should be mentioned: These data also suggested that the higher the intellectual level the greater the value of counseling.

At this point, perhaps definitions are in order. What is the definition of "mental retardation," and what is meant by "counseling"? For purposes of this discussion, the construct "mental retardation" will follow that proposed by the American Association on Mental Deficiency (A.A.M.D.) in the manual edited by Grossman (1953).

> *Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.* (p. 11)

As stated in the manual, "Mental retardation is not a simple disease, syndróme or symptom; it is a state of impairment, recognized in the behavior of the individual and its causes are many" (p. 5). This definition has received wide acceptance and removes the I.Q. as the sole determining factor.

On the other hand, it is somewhat more difficult to establish a definition of counseling that will meet with wide acceptance. Such a definition relates not only to the theoretical orientation of the counselor but, at times, even to the goals of the counseling itself. In terms of this author's thinking, the constructs counseling and psychotherapy can be used interchangeably, with counseling the choice for the purpose of this discussion. Because this author views counseling as a professional helping relationship, he finds Bialer's (1967) "best fit" definition readily acceptable. Bialer defines counseling in the following manner:

> *Systematic utilization of psychological techniques, chief of which is a close interpersonal relationship, by a professionally trained therapist in order to help individuals who need or seek his assistance in the amelioration of their emotional or behavioral problem. The procedures involved may include non-verbal as well as verbal techniques, and the subjects may or may not be aware of the therapeutic process.* (p. 139)

This definition is sufficiently broad in scope to allow the inclusion of a variety of techniques.

The literature on counseling the mentally retarded has focused mainly on the institutionalized retardate and on helping him/her adjust to the institutional environment. In the past, little attention was given to the possibility of taking the retardate out of this setting and helping him/her adjust to the family and community environment. Certainly the school-aged retardate was regarded as needing total programming, a service which could be provided only in a residential training center. This included training not only in self-help and socialization skills but in academic skills as well. It was not until the retarded person reached adulthood that any real consideration would be given, if at all, to placement outside the institution, either in a foster home or, in rare instances, in the individual's home.

More recently, there has been a decided change in attitudes toward the mentally retarded, not only on the part of professionals but of the general public as well. As far as the general public is concerned, much of this change probably emanated from the civil rights issues of the 1960's, and from the work of dedicated professionals who believed that many of these individuals were capable of living outside of the institutional environment. A trend has developed to move the mentally handicapped out of large and impersonal institutions into facilities that are smaller in size and centered in the community or, if possible, into the home. This is the process of "deinstitutionalization." Though initially intended for those who were long-term residents in mental hospitals, the practice was soon being advocated (Elliot & MacKay, 1971; Wolfensberger, 1971) as desirable for those mentally retarded individuals whose limited skills were not being utilized in the institutional setting. In fact, because these individuals were not putting their skills to use, they eventually lost them and became even less capable of functioning at their highest, albeit retarded, level of development. Thus, individuals seemed at times to become even more retarded as they continued to live in the nondemanding and frequently unstimulating environment of the institution. This was especially true of retarded children, whose developmental processes need continued stimulation in order to develop to their fullest capabilities.

Rationale for Counseling the Retarded

Recent studies support the belief that counseling retarded persons should and often does result in positive changes just as does counseling with the nonretarded (Browning, 1974). There is no such thing as a retarded individual without psychological problems, if for no other reason than the fact of his/her retardation. This is believed to be true whether or not the individuals themselves are aware of their retardation. Regardless of the etiology of this condition, it does impose limits on the individual's potentialities. To be sure, the nature and extent of these limitations are determined not only by the individual's intellectual level but also by the nature of the demands of the environment in which the person is to function. On the premise that the retarded individual has the same basic rights as other individuals to develop his/her abilities and potential to the fullest possible extent, to live and participate in community life, and to be protected from exploitation (Baroff, 1974), it follows that he/she has the right to counseling, as well as to education and training, to assist in achieving these objectives. Crowley (1965), in recognizing that the retarded person needs to be treated as a total functioning human being, notes that counseling or psychotherapy with the retarded is conspicuous by its absence. Sternlicht's criticism, mentioned earlier, that this is due to lack of a systematic and comprehensive theory of psychotherapy with the retarded, is unacceptable. On the basis that the retarded have the same adjustment problems and emotional problems as the nonretarded, it would seem that existing theories of personality, motivation, and counseling procedures can be applicable to understanding the behavioral dynamics of the retarded. Much of what are referred to as "emotional problems" are regarded by some professionals as "problems in living" (Szasz, 1960), which can be best dealt with by learning alternative and more adaptive means of dealing with the problems and stresses of daily life. Retarded persons as well as nonretarded persons may encounter "problems in living" and thus find themselves in need of counseling.

In their study of handicapped children, Servis and Carpignano (1976) utilized Maslow's (1954) human motivational theory in evaluating the needs

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of the physically handicapped, most of whom had visible disabilities. They discuss the need of these handicapped persons for counseling because of their psychological reactions to their physical disabilities. An even stronger argument can be made for the counseling needs of retarded persons, especially because their disabilities are nonvisible. It has been shown (Warren & Gardner, 1973) that visible disabilities generally tend to elicit a greater degree of both positive and negative emotional responsiveness from others than do nonvisible disabilities. When an individual has a nonvisible disability, not known to others, he/she is accepted as normal and is expected to behave accordingly. Because the majority of retarded persons possess nonvisible disabilities they receive little, if any, recognition as being handicapped. The paradox this creates is that, though fortunate and to be desired, nonrecognition of the handicap means that others in the environment at times make demands or hold expectations of retardates which they are unable to satisfy, thus leading to frustration and its consequences. In discussing the somatopsychology of the handicapped, Myerson (1955), states that "children who have disabilities, as a group, tend to have more frequent and more severe psychological problems than others" (p. 22). One also finds agreement with his belief that "every disabled person in our culture is going to be frustrated by (some) new psychological situation that may arise because he lacks an appropriate tool for behavior" (p. 47). For the retarded person, this "tool" is average or better intelligence.

Maslow's (1954) hierarchy of basic needs can be applied to understanding the needs of the retarded. This formulation includes the following: physiological or survival needs, safety needs, belongingness and love needs, esteem needs, and self-actualization needs. In this hierarchical system, the basic survival and safety needs must first be satisfied before the higher order needs become influential as a determinant of behavior. Once the basic needs of retarded persons for survival and safety are satisfied, they have, perhaps even more so than nonretarded individuals, very potent belongingness and love needs. Having experienced failure and rejection from both family and society, and having learned that their active participation in decision-making processes both in the family and in the environment is almost nonexistent, mentally retarded persons often develop a distorted and negative sense of self. They feel more limited than they actually are and generalize these negative feelings to areas in which they do have competence, but they are unable to recognize this.

Considerable reinforcement for such pervasive negative self-perceptions comes from the environment. People tend to generalize an organism's singular deficiency to all aspects of that organism, so that if one task cannot be mastered successfully, in all likelihood none can. Such fallacious beliefs have a marked effect on the self-perceptions of the mentally handicapped, who, in their eagerness to relate to their environment, incorporate these external perceptions into their own developing self-concepts, thereby distorting the evaluation of their own capabilities. This concept has an even more destructive aspect because of its circularity. Because the retarded are made to feel grossly inferior and hence insecure in their interpersonal relationships, they initiate very little contact with others. They may even totally withdraw, which only further limits their life experiences. As a result, opportunities to learn more appropriate social and other skills become less available to them and hence reinforce the belief that they are generally incapable persons; thus, they become prey to the "self-fulfilling prophecy" reported by Rosenthal and Jacobson (1968). Their studies demonstrated that teachers' attitudes towards their students influenced the nature of the students' self-concepts, demonstrating the tendency of people to behave in the way in which they are expected to behave. So, a priority goal for counseling becomes apparent: the need to provide warmth and acceptance, and to develop in the retarded individual that degree of positive self-esteem needed to be and to perceive oneself as being a functioning human being. These early objectives are critical in counseling the retarded, for as a positive self-concept develops, it carries with it the motivation to make better use of one's own resources.

It is necessary to help the retarded to develop, as fully as possible, an accurate evaluation of their positive skills and how these may be put to use to compensate for other, less-developed skills. Success in at least some areas of functioning will go a long way toward helping them develop the more positive self-concept necessary for adequate life adjustment.

Additionally, some studies have demonstrated that improvement in self-concept can result not only in improved behavioral adjustments but in improved academic skills as well (Mann, Beaber, & Jacobson, 1969).

Having achieved acceptance as a human being, and having developed some degree of positive self-esteem, the retardate is now prepared to move in the direction of fulfilling the next and highest goal in Maslow's hierarchy of needs--that of self-actualization, which is defined as a person's desire to achieve self-fulfillment, to become actualized in his/her potential (Maslow, 1954). That is, people should utilize the best that is in them and become whatever they are capable of becoming. It means bringing out the highest potentialities in individuals. This is an important concept for the mentally retarded who, because of their limited skills, should be helped to utilize these skills to the fullest extent possible. Burton (1954) stresses the need to counsel the retarded to help free them from emotional conflicts so that they can use whatever intellectual capacities they possess. Thus, another reason for counseling the retarded is evidenced: counseling to help the retarded to utilize as fully as possible the abilities they do possess. This is as important an objective for the retarded as it is for the nonretarded.

The retarded may have as severe psychiatric disorders as the nonretarded, and they should have the opportunity for as intensive counseling as would anyone else with such problems. These may include behavior disorders, neurotic disorders, or even psychotic disorders. That psychiatric disorders can co-exist with mental retardation has become apparent to many professionals who work with the retarded, and more frequent reports stressing the need for counseling these individuals are appearing in the literature. Warren and Gardner (1973) report an increased professional interest in mental retardation, which they attribute to increased publications, increased services by public schools, growth of professional and lay organizations, and new legislation.

Chess (1962), working in an outpatient clinic for mentally retarded children, administered psychiatric treatment to at least three different types of retarded patient population:

> *(1) children whose full use of their limited intelligences are hampered by fears, anxieties and destructive psychological defenses;*
>
> *(2) children who have permanent mental retardation co-existing with psychological problems; and*
>
> *(3) children functioning now as retardates who are potential normals.* (p. 864)

These children ranged in age from 5 to 13 years and their I.Q. scores ranged from 33 to 68. After a 3-year period of experimentation with different psychotherapeutic approaches ranging from verbal to play techniques, it was found that the effects could be determined on a differential basis. The best results were obtained with mentally retarded children who had secondary behavior disorders. Improvement was displayed by the alleviation of fears and anxieties, and this was true no matter how limited was the child's intelligence. Also, some children's behavior improved to the extent that they could be included in some form of normal family living. With "pseudoretardates," children whose retardation was due largely to psychological disturbances, improvement both in behaviors and in test results was sufficient for some to move to a normal level of functioning. Poorest results were reported for the mentally retarded schizophrenic children. Chess believes her findings to be encouraging and feels that counseling should be made more available to retarded children. Though these results, at first glance, may not seem sufficiently positive to establish the benefits of counseling this population, because these subjects comprised a variety of personality and behavior disorders and a spread of I.Q. scores ranging from severely to mildly retarded, the gains made, if any, will need to be evaluated on a differential basis.

Perhaps the immediate focus of counseling should be on the mildly retarded or "educable retarded" population. The prognosis is most favorable with this group, and they can be helped more quickly to assume relatively normal functioning in society and perhaps in the family as well. Counseling the lower-level retarded population involves a more prolonged time period, results may not be as dramatic and noticeable, and changes may be slow in coming. Counselors tend to utilize their skills in directions that will yield the quickest beneficial results, and so it is understandable that they seek reinforcement for their efforts through observable change in their clients. Psychologist-counselors, experienced in working with the retarded, believe that the higher the level of intelligence of this population, the greater the value of counseling (Hutt & Gibby, 1965).

In discussing the effectiveness of counseling the mentally retarded, Sternlicht (1978) formulated an etiological counseling model which includes a prognostic index. In his schema, he rules out counseling of retarded whose condition results from neurological deficit as well as counseling of retarded whose condition is a function of cultural deficit, both on the basis of ineffectiveness. He does, however, believe that mental retardation which is due to emotional factors is treatable through counseling. In such cases, alleviating the emotional disturbance results in increased I.Q. and subsequent removal from the domain of retardation. Sternlicht also includes as amenable to counseling those individuals who develop personality maladjustments because of their own emotional reactions to their intellectual deficits and the consequences of such: social and familial rejection, sexual restrictions, lack of a positive self-concept, and restriction of freedom. He believes that counseling should be capable of helping retardates achieve better adjustments to reality without necessarily increasing their I.Q. levels.

Characteristics of the Counselor

Counseling, whether individual or group, involves a close, interpersonal relationship between the counselor and the client which includes a mutual understanding of the relationship and its purpose. This understanding is especially important for the counselor who works with mentally retarded persons. Sawrey and Telford (1967) believe that this understanding is represented in two forms: diagnostic understanding and therapeutic understanding. The former involves an intellectual understanding of the client's behavior and is part of a counselor's training. The latter, which is emotional, involves development of a relationship between counselor and client which enables the client to feel that he/she is understood and accepted by the counselor. Counselors of the mentally retarded must not only have such understanding but must also be eager and willing to accept these individuals on whatever level they are functioning.

Sternlicht (1978) believes that personality factors of the counselor are most important in the relationship. He states that "extreme professionalism is not called for, but the qualities of a good mothering individual are. The ability to love is absolutely essential" (p. 458). Thus the first important requirement of a counselor working with the retarded is to be most warm and accepting. In discussing common factors in diverse approaches to counseling the retarded, Bialer (1967) quotes Cowen and Trippe who regard the client-counselor relationship as the most important single factor in any counseling approach: "The essence of therapy is not the response of the client to therapeutic techniques... it is his response to another person" (p. 154).

A second requirement is that the counselor sincerely believe that the mentally retarded can achieve gains through counseling. The counselor's attitude must be positive and must include the conviction that the retarded can be helped. In discussing the training of counselors, Porter (1950) stresses the importance of the counselor's attitudes as well as skills, and believes that the two are interrelated. These positive counselor attitudes must extend to the families of the retarded as well. The counselor must appreciate the needs of the family and the impact on them as a consequence of having a retarded child. He/she must be free from stereotypes about retardation, including the belief that this condition is inherited and associated with other deviancies like mental illness (Halpern & Berard, 1974).

Third, the counselor must have extensive knowledge of the field of mental retardation as well as experience with the retarded in areas other than counseling. He/she must have knowledge of the medical, educational, social, and psychological aspects of retardation and must also know as much as possible about programs and community resources. Wolfensberger (1971) emphasizes knowledge of such resources in its broadest sense. In his opinion, the counselor's professional affiliation is irrelevant, and neither a medical nor any other degree itself qualifies or disqualifies a person from counseling the retarded.

A fourth characteristic concerns the counselor's competence in counseling the mentally retarded. The counselor's training should cover a broad spectrum of counseling techniques and principles, including knowledge of his/her own limitations. In addition, he/she must be capable of and willing to utilize a variety of techniques as required, rather than be a loyal adherent of one particular counseling approach. Sternlicht (1978) believes that many counselors who have been trained in verbal techniques and who have invested much time and effort into perfecting these techniques will be resistive to nonverbal techniques. Such inflexibility has no place in counseling the retarded.

There is no such thing as a "mental retardation personality"; mentally retarded persons possess as varied personality patterns as do nonretarded individuals. The counseling technique most appropriate for one retarded person may be inappropriate for another. Thus, the counselor needs to be experienced with and capable of applying a variety of counseling methods, the choice being dictated by the needs of the client rather than by the particular orientation of the counselor. Further, it may become necessary at times for the counselor to change approaches during the course of counseling with the retarded person because of changing needs. There are times when the counselor needs to be nondirective, warm, and reassuring; there are other times when the most appropriate technique with the same individual is direct intervention and firmness. The counselor needs to be able to make such shifts in technique comfortably, whenever required, and with full knowledge that he/she is capable of doing so. Also included in this adaptive role is the ability of the counselor to assume varied role functions as perceived by the retarded counselee. The counselor may at various times need to fulfill the role of parent, sibling, or friend, in addition to that of counselor.

As a fifth requirement, the counselor should be capable of assuming the role of advocate for the mentally retarded client. One of the counselor's responsibilities is to be active in the development of the client's habilitation plan, and he/she must always favor only those programs that are believed to be in the best interests of the client. This includes not only educational programming but personal, social, and vocational programming as well. No domain of the retarded person's life space should be beyond the concern of the counselor. Thus, the counselor is often actively involved with the retarded client beyond the actual counseling session itself. This is one of the major ways in which counseling the retarded differs from counseling the nonretarded: In the latter, the counselor's active role is usually confined to the counseling session itself with outside involvements a function of the client's own actions. Irrespective of the technique employed, the counselor working with a retarded person needs at least initially to accept responsibility for directing the client's life plan. As the retarded person becomes more capable of adequate decision-making, more responsibility is transferred from the counselor to the client, but the authoritarian and sometimes "magical" role assigned to the counselor by the retarded client never completely disappears. In the eyes of the retarded client, the counselor is viewed as capable of bringing about fulfillment of even the most unreasonable demands, a conviction which often strains the best of such counselor/client relationships.

This leads to the sixth important requirement of the counselor: a very high tolerance for frustration. Counselors working with a retarded population may have demands put upon them that are beyond their abilities to fulfill, whether because they are therapeutically inappropriate, unreasonable, or simply unrealistic. The persistence of many retarded in viewing their counselor as being capable of fulfilling almost any demand means that the counselor must exercise patience, be tolerant of abuse, and never be intimidated by the retarded client. The counselor must be able to accept regression as well as progress in behavior without becoming angry with the client for failure to achieve and without losing confidence in his/her counseling ability. The counselor must always be aware that positive change is often slow in coming. In fact, the counselor must learn to recognize subtle and often minute changes in behavior which may come only after many hours of counseling and not feel frustrated because greater expected gains did not materialize.

The School-Age Retarded Child

Legislation on both the federal and state levels and its subsequent implementation have had a major impact on educational programming for the retarded school-age child, especially the mildly retarded or educable retarded child. The intent of such legislation is to remove retarded children (or any other handicapped children) from special schools or classes and to educate them in the "least restrictive environment." This means that they are to be educated with children in regular classes to the maximum degree possible. This effort has come to be known as "mainstreaming," a term which, because of its newness in the field of special education, still creates confusion. A broadly accepted definition of mainstreaming is that offered by Kaufman, et al. (1975):

> *Mainstreaming refers to the temporal, instructional and social integration of eligible exceptional children with normal peers based on an ongoing, individually determined, educational planning and programming process and requires clarification of responsibility among regular and special education, administrative, instructional and supportive personnel.* (p. 40)

half or more of the time. This transition from a homogeneous group in a special class to a more varied group in a regular class geared to the nonretarded population presents the retarded child with academic problems as well as personal and social ones. One of the early studies stressing the need for supportive counseling services for educable mentally retarded children was reported by Fine (1969), who found that educably retarded boys were less secure and showed more defensive behavior than a similar age group of normal boys.

A more recent report (DeBlassie & Cowan, 1976) which underlines the need for counseling the educable retarded child states that these children exhibit a greater need for counseling at two special times in their lives: first, when they enter school, and second, during adolescence. The process of mainstreaming has resulted in retarded children frequently being placed into regular classes without adequate counselor preparation of either the retarded child or his/her nonretarded classroom peers. Studies have shown that the mainstreamed child may encounter considerable rejection not only from other children in the regular classroom but from the teacher as well (Horne, 1979; Martin, 1974). Martin (1974) states that we need to be aware that the negative attitudes and overt rejection displayed towards handicapped children by their more normal classmates are also displayed by principals, teachers, and teacher aides--attitudes that are similar to those of the general public in this respect. Such attitudes of rejection result in anxieties and fears which make it even more difficult for the retarded child to adjust in the "new and normal" environment.

In reviewing educators' attitudes toward mainstreaming, Alexander and Strain (1978) found that regular classroom teachers, especially those with little or no experience in the field of special education, not only oppose mainstreaming but also believe that the mentally retarded cannot benefit from regular classroom placement. These negative attitudes have a direct effect on the mainstreamed students' adjustment to their new classroom environment (Brophy & Good, 1970). Counseling with school-age retarded children must begin prior to their transfer to the regular classroom and continue on a regularly scheduled basis throughout the transitional period--and beyond, if required. Even if the retarded child has no serious emotional problems, he/she will have problems adjusting to the frustrations encountered in trying to integrate into the normal classroom. The counselor's participation in this transitional period is essential. He/she needs to be available and supportive, and alert to detect problems as soon as they appear, which requires that the counselor play an active and directive role. The counseling relationship itself must be one that involves mutual understanding and trust. The child must believe that the counselor is functioning in the child's best interests; the counselor must accept the child's individuality and the child's right to make errors, perhaps even to a greater extent than normal children do, without becoming discouraged. Any negative feeling toward the child on the part of the counselor, covert or overt, will be destructive to the counseling relationship.

School-age retardates are especially sensitive to authoritarian relationships because of their many years of almost total dependency in early childhood, and they have a strong need to believe in the total support of their counselor. In discussing counseling the educable retarded child, DeBlassie and Cowan (1976) state,

> *(These) children should receive support for their anxieties and for reality pressures...The counselor should also support the children's efforts to cope with these anxieties even though their modes of attempting to handle them may be inadequate. The children can then be helped to develop adequate coping behaviors.* (pp. 249-250)

Heron (1978), in a rather stimulating article on coping with problems of mainstreaming, suggests a composite decision-making approach for maintaining the exceptional child in the regular classroom. When a problem arises, he proposes separate strategies for the mainstreamed child, for the regular child, and for the teacher. These strategies suggest alternative behaviors or combinations of alternatives which each of these three stated groups can follow to insure success of the mainstreaming process. Because this author believes that Heron's proposals can be utilized profitably by the counselor of the school-age retardate without jeapordizing the individuality of the counselor's techniques, these strategies will be discussed in brief detail.

First, strategies for the mainstreamed retarded child. As mentioned earlier, the counselor should be working with the retarded child prior to the mainstreaming event itself. He/she must be knowledgeable about the child's strengths and weaknesses, not only with respect to academic skills but also, perhaps even more important, with respect to personal and social adjustments. The composite process is used only after the child has been mainstreamed, has had some time to adjust, and is now presenting problems to the regular teacher. As Heron suggests, the first step is to define the problems (whether academic, social, or personal) and to identify "the probable agents of change" (p. 211). Heron raises this question:

> *Can the problems exhibited by the mainstreamed child be solved by focusing attention primarily on the mainstreamed child's behavior, the behavior of the peer group or the teacher's behavior?* (p. 211)

Because of the counselor's knowledge of the child's skills, and because of his/her advocacy role as mentioned earlier, the counselor is the most logical person to pursue the answers to these questions and eventually to present them to the educational planning team responsible for the retarded child's instructional program. With respect to the child's personal and social adjustment problems, the strategy could be utilized more frequently and perhaps in even more intensive counseling sessions until the problems no longer interfere with the mainstreaming process.

Second, strategies for the regular child. In suggesting strategies for helping the regular child to become more accepting of the retarded child, Heron believes that both the principal and the teacher should play a more active role in introducing the mainstreamed child to his/her new classmates. This author believes that the counselor can also assume an active role in this regard. Because of his/her general knowledge of retardation and understanding of the child to be mainstreamed, the counselor is in a position to advise school personnel on appropriate steps to take to incorporate the retarded child into the classroom. Enright and Sutterfield (1979) discuss the role of the regular class child in the mainstreaming process. They accept Kohlberg's cognitive development school of thinking which believes that "a child misbehaves because he or she does not understand some aspect of the situation in which the misbehavior occurred" (p. 111). They believe the teasing and rejection of the retarded child by regular class children to be a function of the latter's poor social cognitive development and that if this social cognition were improved, it would enhance the chances of success of the mainstreaming program. This suggests an additional role function for the counselor. Not only should he/she participate in programs designed to develop higher social and moral values in the regular class child, he/she should also be the one to introduce the retarded child to the new environment.

Third, strategies for the regular class teacher. The strategies for the teacher as suggested by Heron would be to "personalize" the environment (through changed seating, tutoring, and the like), to teach prerequisite skills, and to use behavior modification techniques. These would only indirectly be the concern of the counselor. The counselor, however, can play a direct role by providing inservice training programs for those teachers who have had little or no working experience with the retarded. It has been demonstrated that lack of experience and training in the area of special education is largely responsible for the negative attitudes of many regular classroom teachers toward the retarded child. Thus, the counselor can play an effective role in this final strategy to achieve successful mainstreaming of the retarded child.

The Adult Retarded Person

Counseling the adult retardate has a somewhat different focus than counseling school-age children. Emphasis is less on learning basic academic skills and more on learning to live with other adults in both a working and social relationship. More recently, the emphasis has been on learning to live with one's own family (or a surrogate or foster family), to be a part of one's home community, and to have the right to productive work or other meaningful occupation. This has been clearly stated in the now familiar principle of "normalization," the essence of which is to include the retarded person in the world in which the rest of us live (Baroff, 1974). Nirje (1969) describes this normalization principle as "making available to the mentally retarded, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society" (p. 231). A variety of community-living arrangements are now beginning to emerge: group homes, half-way houses, sheltered workshops, and day-care centers. McMillan (1977) reports statements of those who advocate new service-delivery models with a phasing-out of the old, large institutions. They claim that smaller programs are more humane, more individualized, and less expensive. "Normalized" environments were described by Roos (1963) as "homelike"--including private bathrooms, small dining areas, lamps, rugs, and the kind of furniture found in typical homes. Those who advocate such normalization believe that these changed environments will produce positive changes in the personalities and development of retarded individuals. McMillan (1977) argues, however, that research has not shown this to be so. It is claimed that although these retarded are a part of the community in a physical sense, they are not so either psychologically or socially. What is needed is an intensive counseling program, along with such community placements, to help these individuals gradually merge with the normal social and psychological environments into which they are often thrust. Thus, this very concept of normalization makes almost mandatory the offering of specialized services for this population.

Throne (1975) believes that specialized procedures should be made available to the retarded to help them derive maximum benefit from "normalization." Though he accepts normalization as a goal, he does not agree that it operates to the advantage of the retarded. It is his opinion that "normative procedures work best for persons who are normal; they tend to go over the heads of persons who are retarded" (p. 24). He believes that normative procedures reduce the probability of helping the retarded because they interfere with the application of specialized procedures. Thus, special placement requires specialized procedures to help insure its success. Merely placing a retarded person in a normal environment will not in itself result in successful adjustment, unless the placement is accompanied by the necessary tools for survival in it. Counseling services, especially at the beginning of placement, would seem to be one of the tools necessary to assure effective adjustment to the placement. Zipperlen (1975), in her discussion of the "normalization" principle, views it as an opportunity for the retarded to give something to society as well as to receive from it. She states, "All people have something to give, and the greatest imprisonment is to deny the opportunity to give it, to be genuinely needed by the people" (p. 274).

Alternatives to normalization have recently appeared in the literature. Mesibov (1976) suggests the application of the humanistic goal of "cognitive ecology" or positive self-feeling. He presents it as a measurable goal which focuses on the individual, the important criterion being the degree of positive self-regard possessed by the individual. Because counseling has as one of its major objectives the development of a positive self-concept, it would seem that counseling should be a requirement in such a cognitive ecological approach. Studies show that deinstitutionalization through placing the retardate into a "normalized" community residence is not always successful (Crawford, et al., 1979). Birenbaum and Re (1979) studied an organized community of retarded adults called "Gatewood." This was a 4-year longitudinal study of retarded adults from three state schools who had been resettled at a community residence in a large city. Results indicated that though they continued working in sheltered workshops and maintained some interpersonal relations with peers, they failed to become more self-reliant and also made less use of leisure time activities than expected. There was the feeling that some of these individuals showed regression in behaviors.

Perhaps an important point needs to be made here. Recently the idea has been stressed that treating retarded people normally will result in their behaving in a more normal manner. To some extent this holds true, but the fact remains that they still lack some of the "tools" (as indicated earlier) for meeting the complex and often frustrating circumstances of community living. Because the need to have personal counseling is still looked upon as a "weakness," we have bent over backwards to avoid stigmatizing retarded persons. We have returned retardates to the community in most instances without supplying supportive services for them--the very people who need these services. As indicated in other reports (Mesibov, 1976), retarded persons do need extra help; and although they may never become normal, they can, in most instances, learn to adjust to their environment in as close to normal a manner as possible and maintain a fairly contented existence. But usually this cannot be accomplished without their initially receiving some form of supportive counseling. It is in this direction that we must strive if any form of normalization is to succeed.

Because in our society one's vocational accomplishments play a major role in determining the level and degree of acceptance by others, it is as important for the retarded as for the nonretarded to achieve as adequate a working adjustment as possible. A working retardate will more likely make a better adjustment than one who is not working, because of the feelings of self-worth and of being held in higher esteem by others.

Wolfensberger (1967) proposes a vocational creed for retardates which he believes "reflects the cultural values of American society as well as the principles of habilitation of the retarded" (p. 232). This creed states generally that the retarded person who is working derives considerable benefits beyond his wages: favorable community attitudes, better family adjustments, material benefits, and the like. Thus, a major goal of the counselor working with adult retardates is to help them achieve an adequate vocational adjustment. Wolfensberger also reports that many retarded adults fail to make a satisfactory work adjustment because of personal and social deficiencies rather than inadequate job skills. He finds some of their common problems to be lack of appropriate training, unwillingness to risk failure, lack of initiative, and inappropriate social behavior. In discussing the counseling of the mentally retarded worker, Halpern and Berard (1974) recommend that the counselor pay close attention to the personal and social demands of the client's work environment in order to insure a successful work adjustment. Recent practices and legislative rulings have combined to stress the role of public education in the preparation of the retarded for eventual employment. P.L. 94-142 mandates the education of handicapped children up to 21 years of age, thus placing early vocational education into the realm of junior and senior high school curricula. This includes prevocational as well as vocational programs in addition to academics. Because skills, interests, and personal and social values are important to successful work adjustment, the role of the counselor with this population assumes special significance. Retarded adolescents and young adults need counseling services aimed at insuring successful job placement as well as continued adjustment to family and community.

Recognition of the need to provide educational experiences during the high school years to mentally retarded adolescents and young adults that prepare them for gainful employment has led to the development of work-study programs for this population. The development of such programs is reviewed by Cegelka (1974). This report reveals that such programs have a history both in vocational training and in federal legislative efforts. For more than 25 years there has been increasing emphasis on vocational rehabilitation for the retarded, the goal being a return to the community rather than custodial care in an institution. Studies have indicated the value of vocational training in addition to personal and social skill training for young adults. This could take place in high school in some form of on-the-job training, in sheltered workshops, and even in real employment situations. The retarded worker would receive the same pay as his nonretarded counterpart for equal amounts of productive work.

The counselor's role in work-study programs not only includes the usual counseling services (personal and social) but also some form of vocational counseling. It is a *sine qua non* that the counselor have sufficient knowledge in vocational areas, in addition to other requirements, to counsel the adult retarded. In addition, it becomes the counselor's function to help employers develop more positive attitudes toward the retarded. The need for counseling prospective employers concerning the work habits of retardates was clearly evident in the Mansfield Project (Burrow, 1974), whose objective was to demonstrate that the mildly retarded could function adequately in a variety of competitive work situations. It was found that each employment manager or personnel director had his/her own ideas, including misconceptions, about the nature of retardation and how it affected the retardate's work adjustment.

The importance of the counselor's role in the first of four phases of work adjustment was evidenced in the report of a transitional workshop (Hallenbeck & Campbell, 1974). The philosophy of this program was that work adjustment is a four-phase process: "setting in, learning, growth and job readiness" (p. 183). The behaviors reportedly found in phase one were described as a "wait and see" attitude, lateness, absenteeism, and working slowly. These were attributed to problems of anxiety and difficulties in getting along with supervisors and/or fellow workers. It was recommended that counseling sessions be instituted at the start to help overcome these initial problem behaviors. It was reported, too, that adjustment during the remaining three phases was facilitated by counseling.

Parental and Family Role Functions

Behind almost every retarded person is a family of some kind. This may consist of parents and/or siblings or it may be an "extended" family. Even in situations where the retarded member has been removed from the family through "permanent placement" in some facility, family involvement still remains. In more recent times, families have become more active in the education and care of their retarded member. This has come about because of the emphasis on normalization, because of legislative advances in the field, and because of the many active parent organizations organized to pursue the interests of the retarded. Thus, no longer can any counseling program for the retarded afford to exclude the family.

When working with retarded children, the counselor must now involve the parents, if for no other reason than that it is mandated by law (P.L. 94-142). Parents have to be made aware of the counseling program in advance of its implementation and, in most instances, must give their approval. Beyond this legal requirement, counseling with the retarded usually requires changes in the environment as well as changes in the individual, thus necessitating that the family assume some place in the counseling program.

Halpern and Berard (1974), in their review on counseling the mildly retarded or "educable" group, state that these individuals usually live at home with at least part of their family and that this family typically belongs to the lower socioeconomic class, though it may belong to the upper middle class as well. The authors categorize the families of these mildly retarded in two groups: the stable lower-class family and the poverty-stricken family. It is their belief that the stable lower-class family is capable of supplying its retarded member with sufficient warmth, reasonable health care and nutrition, and personal acceptance. Because these parents have had limited schooling, however, they provide inadequate role models for academic accomplishments. In contrast, the poverty-stricken family has little to offer its retarded member. Poor health, unsanitary living conditions, and little emotional security characterize this group. Implications here for the counselor are important. The stable family can usually be counted on for long-term cooperation with the counselor, but the poverty-stricken family is not capable of such cooperation. Halpern and Berard conclude with the following recommendation:

> *When the family of a retarded client is fairly stable, they should be incorporated into the counseling process. When such stability does not exist, the chances of helping the client are minimal, unless extensive family counseling can be initiated or the influence of the family on the client can be weakened.* (p. 272)

Sternlicht (1978), in an excellent review of research on psychotherapeutic procedures with the retarded, reports agreement on the value of helping parents to cope with the many problems inherent in their situation and the beneficial effects this has on the retarded child. He reports some agreement that group counseling is more effective with parents than an individual approach, but that some investigators continue to prefer individual counseling, preferably analytic in nature. Sternlicht (1966) strongly advocates the three levels of group counseling proposed by Blatt (1957) as follows:

> I. *Educational Group Counselling: to include those parents whose defenses are fragile and brittle...*
>
> II. *Group Counselling: to include those parents whose ego strength is sufficiently strong to explore their attitudes and feelings as related to the child.*
>
> III. *Group Psychotherapy: to include those parents who indicate a desire to delve into their own emotions and feelings. This would only incidentally be related to the child.* (p. 333)

Parents should be given an option to join a group of their choosing. Obviously, many differences exist in the problems presented by parents, and their abilities to cope with them should determine the level of the group they join. In large measure, the impact of the retarded child on a given parent will determine the intensity of counseling that is necessary. Wolfensberger (1967) reports that the most prevalent parent reaction is guilt, sometimes preceded by anger, and that most often this guilt is without basis in reality. Other reported reactions include ambivalence between frustration, grief and disappointment on the one hand and the impulse to love and protect on the other. Wolfensberger believes that parents undergo three types of crises, with some experiencing all, others one or none. The first crisis he refers to as "novelty shock," which occurs when the diagnosis of retardation is presented to a parent not expecting any problem (e.g., a Mongoloid baby). The second crisis he calls a "value crisis." The retardation is viewed as preventing the achievement of the value systems expected by the parents. This attitude usually leads to institutional placement and denial of the existence of the retarded child. The third crisis he terms the "reality crisis." Forces external to the parents make it impossible to keep the retarded child at home, such as death of a spouse or the physical demands of the child. The counselor needs to determine the nature of the parents' reactions and to proffer the counseling technique best suited to the particular parent(s).

In reviewing the many different ways in which parents can react emotionally to the fact of their child's retardation, Hutt and Gibby (1965) present three typical parental behavioral reaction patterns. First, there is the "accepting parent" who exhibits a mature and realistic acceptance of the child's retardation. This type of parent will not be in need of intensive or prolonged counseling because of having already demonstrated the major goal of counseling: acceptance of the child. Second, there is the "disguising parent" who attempts to hide the condition from others and even from him/herself. Such parents perceive that something is wrong, but cannot accept the limited intellectual capacities of their child. They search for some medical factor causing the condition. They may attribute academic difficulties to poor instructional methods and seek tutoring to bring the child up to a normal academic level. These parents require more intensive and prolonged counseling, initially on an individual basis, in which they are encouraged to express their feelings openly and learn gradually to recognize their unrealistic beliefs. Later, they should join a counseling group of similar parents where they can share their feelings and receive group support that will lead to eventual acceptance of the situation. The third type of parent is the "denying parent." This represents the most severe parental reaction of the three. It is a complete denial of reality and, as such, involves deeper psychological problems which the parent must overcome. Behaviors of denying parents are not deliberate avoidance behaviors but rather strong defense mechanisms which take a long time to resolve. Individual counseling of an intensive, nondirective nature would be the therapeutic choice for this type of parent. It is difficult for the counseling relationship to "get off the ground" in this situation; thus, it is important for the counselor to proceed cautiously, allowing the parent to ventilate freely, perhaps for many sessions, before attempting any reality confrontation. This type of parent, after a number of "release" interviews on an individual basis, may further profit from admission to a parent group counseling program.

Mahoney (1958) reported a study stressing the need for counselors to recognize psychological differences among parents of retarded children. The parents' own level of psychological adjustment, even prior to the discovery of the retardation, has a direct bearing on their ability to derive any benefit from individual or group counseling. Mahoney found that the parent who was well adjusted previous to the birth of the retarded child experienced the situation as a "temporary trauma" which could be helped through a supportive counseling relationship. On the other hand, parents who were already maladjusted needed intensive psychological counseling. Other studies reviewed by Sternlicht (1978) support these findings. They all point to the importance of carefully screening parent needs before embarking on any parent counseling program. Researchers agreed that the stigma of retardation was very distressing to parents who kept the child at home and that this family was in greater need of immediate help. Parents who institutionalized their children, however, suffered from greater feelings of guilt. Sternlicht (1978) describes a parent counseling group in which the leader was initially supportive and provided a permissive atmosphere in which the parents were free to express their strongest feelings. As counseling progressed, the leader moved on to explore the parent's feelings with respect to the retarded child. In the third and final phase, the focus was on the parents' own problems. Nadal (1961) emphasizes that the principle objective of any program of parent counseling is to improve the functioning of the mothers

> *by relieving their anxieties, offering them alternative suggestions on child-rearing, increasing their repertory of possible solutions to the problems they face, and modifying their destructive attitudes and behavior.* (p. 81)

Support for direct counseling services to parents of the retarded appears in a discussion by Wortis (1972). Wortis believes that counselors are too psychiatrically oriented and view the parents' needs in terms of psychological treatment to the neglect of the family's direct service needs. He reports studies which indicate that parents have always stressed their need for counseling on how to care for their child's needs (medical, educational, vocational) rather than counseling for their own problems. A similar view is held by Doernberg (1972) who stresses the need for counseling that will help parents to make decisions concerning their retarded child at every stage of the child's life. She believes that parents can be trained to be teachers of their own retarded children, especially in view of the fact that there are not enough trained counselors to meet the needs of the retarded and their families. Doernberg does not deny the need for psychodynamically-oriented counseling, but believes that this is not always the most urgent need. It is more important for some parents to be given specific information and direction about everyday problems of living, and it is the counselor's obligation to supply it. Wortis (1972) suggests that parents be regarded as "paraprofessionals" and describes the tremendous advantages of this approach: There would usually be two parents to help every child, the practice would be economical, the teaching could go on for the greater part of the day, and the child would become an integral part of the family life.

Group Counseling

The objectives of group counseling are very similar to those of individual counseling. The techniques and principles are also very much the same. With some retarded, group counseling may follow individual counseling, while with others the group approach may be the initial treatment of choice. Some cases are best treated with a combination of the two, with the counseling rotating between individual and group sessions. The reasons for using group counseling procedures may vary, but at least one has found general agreement: Group counseling is a more economical approach because it enables more individuals to receive services (Stacey & DeMartino, 1957; Sternlicht, 1978). Lack of funds and staff shortages have resulted in wider use of the group approach. Some believe, however, that it is the only appropriate form of counseling with retardates, especially with those who are mildly retarded (Foss, 1974; Jakab, 1970).

This author believes that group counseling of a verbal nature is more appropriate for the adolescent and older retarded, and that nonverbal group techniques (art, music, play) are most effective with younger retardates. As with other counseling methods, the objectives of the group will determine both its composition and the nature of the counselor's approach. Sternlicht (1978) separates a number of studies on group counseling approaches on the basis of those used in institutionalized and noninstitutionalized environments. He also divides them into largely directive and largely nondirective counseling techniques. These studies seem to indicate that with institutionalized retardates, a more directive approach is desirable; with noninstitutionalized retardates, a more nondirective approach is beneficial. Perhaps the objectives of the group are more essential in determining the success or failure of the counseling method.

The content of group discussions may range from a specific problem to general discussion of attitudes, beliefs, or whatever. Almost no topic is ruled out as inappropriate, the rationale being that if one group member sees fit to introduce it, others might like to but may be reluctant to do so.

In the author's experience, members of the counseling group are themselves capable of limiting the verbal discussions to appropriate topics--seldom does the counselor need to intervene. As stated by Foss (1974) in his discussion of counseling the mentally retarded,

> *If the counselor is free to allow the group to move where it will because he believes in the basic forward moving nature of each of his clients, group counseling can be a successful counseling method as well as an enjoyable experience.* (p. 266)

With adolescent and young adults, peer interrelationships are of utmost importance. The group members are more responsive to each other than to the group leader. It has been this author's experience that groups function best when they are made up of individuals whose intellectual levels are similar but whose adjustment problems are dissimilar, whether the groups are conducted in an institutional or noninstitutional setting. The ability to cope with a specific problem situation may reflect one group member's strength or another's weakness. The heterogeneity of the group is what permits appropriate role models to function. Additionally, the approval and disapproval of certain behaviors by the counselor, as well as by the group, serve as a learning situation for all group members in which they can generalize the nature of these reinforcements to themselves without direct exposure of their own behaviors. In one counseling session conducted by the author with a group of mildly retarded young adults, a group participant was discussing a specific topic when she was abruptly interrupted by another group member. The expressed disapproval of some in the group, together with that of the counselor, served as sufficient reinforcement to all group members not to interrupt a speaker that this "rule" prevailed for many sessions that followed. In this instance, the unacceptable behavior of one group member served as a role model for the others without their having to be subjected personally to negative reinforcement by either the group or the counselor. It is this availability of alternative behavioral models demonstrated by group members which Jakab (1970) regards as a major advantage of group therapy with retarded clients. Group sessions enable the counselor to observe personal and social interactions among the individuals in the group as well as permit group members to observe and practice interpersonal skills.

Where community placement is being considered, the technique of role playing may be used to evaluate and/or practice readiness for such placement. Other reports indicate the use of group therapy prior to return to the community (Appel & Martin, 1957; Kaufman, 1963). Any variety of such roles can be created and "acted out" in the group session under the watchful eye of the counselor. In one of the programs conducted by the author, role playing was used in the group to counsel the members with respect to personal adjustment skills. Roles are constructed to focus on specific individual adjustment problems, and different group members are given an opportunity to role play these problem areas. These may include such areas as quarreling, cheating, temper outbursts, stealing, religion, sex education, or how to behave in a variety of public settings. Group discussions are then held under the direction of the counselor, with all present evaluating the various aspects of the roles as played and discussing the pros and cons of the behaviors. A number of studies reporting such uses of group counseling methods with the retarded are excellently reviewed by Sternlicht (1978).

A Look Ahead

Several factors are having a desirable impact on both the present and the future of counseling services for the retarded. These include new legislation and recent trends such as the emphasis on civil rights for the handicapped, mainstreaming, and normalization concepts. The mandate to return the retarded child to the regular classroom and the retarded adult to community living, wherever possible, underwrites the need for trained counselors to become more involved in these transitional activities.

More specifically, there is an increasing need for counselors in school systems to become actively involved in mainstreaming programs. The retarded child needs to be counseled in the adjustment process involved in regular classroom placement, and the regular classroom teacher may need to be counseled concerning the personality strengths and weaknesses of the mainstreamed child.

With respect to planning an individualized educational program for the retarded child (I.E.P.), it has been this author's experience that to be successful, the program must take into account the personal and adjustment problems of the individual child. It is in this area that the counselor's input is essential. If the transition is to be successful, the counselor will need to supervise carefully each mainstreamed child's adjustment progress. This assumes that school and other counselors will be thoroughly familiar with personality and adjustment problems of mentally retarded children. Because mainstreaming involves parents and family interrelationships, counselors will also need to be knowledgeable about the psychodynamics of parent and family life. Where necessary, counselors should be given the opportunity and support to acquire such knowledge.

With the adult retardate, the concept of normalization means that the counselor should be knowledgeable concerning community relationships, community attitudes, and to some extent vocational information. Counseling involves helping the individual adjust to the realities of life, and laws pertaining to the retarded are part of these realities. Thus, the counselor will also need to be thoroughly familiar with the many recent legislative actions concerning the mentally retarded.

Although it may seem that these statements suggest a kind of "Utopian" counselor, it should be emphasized that the successful counselor must have some expertise and knowledge about counseling the retarded. Just as counselors develop skills in other specialized counseling techniques, so can they develop skills in special areas of counseling the retarded. These may include such areas as mainstreaming, normalization, and law. Perhaps we are moving toward the development of a professionally trained counselor identified as a "transitional specialist in mental retardation." The primary focus of this specialist would be on improving the adjustment process of the retarded child or adult in the mainstreaming or normalizing environment. It appears to this author that transitional actions are frequently initiated either at someone's request or in compliance with some regulation or law. Traditionally, little or no counseling around the time of transfer has been given either to the individual being relocated or to the receiving environment in the interest of preparing all concerned for the myriad of adjustment problems inherent in the transfer process. It is this role function that would be the responsibility of such a "transitional specialist."

REFERENCES

Abel, T. M. Resistance and difficulties in psychotherapy of mental retardates. *Journal of Clinical Psychology*, 1953, *9*, 107-109.

Alexander, C., & Strain, P. S. A review of educators' attitudes toward handicapped children and the concept of mainstreaming. *Psychology in the Schools*, 1978, *15*, 390-396.

Appel, E., & Martin, C. H. Group counseling for social adjustment. *American Journal of Mental Deficiency*, 1957, *62*, 517-520.

Baroff, G. S. *Mental retardation: Nature, cause and management*. Washington, D. C.: Hemisphere, 1974.

Bialer, I. Psychotherapy and other adjustment techniques. In A. A. Baumeister (Ed.), *Mental retardation: Appraisal, education and rehabilitation*. Chicago: Aldine, 1967.

Birenbaum, A., & Re, M. A. Resettling mentally retarded adults in the community: Almost 4 years later. *American Journal of Mental Deficiency*, 1979, *83*, 323-329.

Blatt, A. Group therapy with parents of mentally retarded children: A preliminary report. *Group Psychotherapy*, 1957, *10*, 133-140.

Brophy, J. E., & Good, J. L. Teacher's communication of differential expectations for children's classroom performance. *Journal of Educational Psychology*, 1970, *61*, 365-374.

Browning, P. L. *Mental retardation: Rehabilitation and counseling*. Springfield, IL: Charles C. Thomas, 1974.

Burrow, W. H. Job development a problem in interpersonal dynamics. In L. K. Daniels (Ed.), *Vocational rehabilitation of the mentally retarded*. Springfield, IL: Charles C. Thomas, 1974.

Burton, A. Psychotherapy with the mentally retarded. *American Journal of Mental Deficiency*, 1954, *58*, 486-489.

Cegelka, W. J. A review of the development of work-study programs for the mentally retarded. In L. K. Daniels (Ed.), *Vocational rehabilitation of the mentally retarded*. Springfield, IL: Charles C. Thomas, 1974.

Chess, S. Psychiatric treatment of the mentally retarded child with behavior problems. *American Journal of Orthopsychiatry*, 1962, *32*, 853-869.

Chidester, L., & Menninger, K. A. The application of psychoanalytic methods to the study of mental retardation. *American Journal of Orthopsychiatry*, 1936, *6*, 316-325.

Crawford, J. L., Aiello, J. R., & Thompson, D. E. Deinstitutionalization and community placement: Clinical and environmental factors. *Mental Retardation*, 1979, *17*, 59-62.

Crowley, F. J. Psychotherapy for the mentally retarded: A survey and projective consideration. *Training School Bulletin*, 1965, *62*, 5-11.

"Declaration of general and special rights of the mentally retarded." International League of Societies for the Mentally Handicapped. Oct. 1968.

DeBlassie, R. R., & Cowan, M. A. Counseling the mentally handicapped child. *Elementary School Guidance and Counseling*, 1976, *10*, 247-253.

Doernberg, N. L. Parents as teachers of their own retarded children. In J. Wortis (Ed.), *Mental retardation IV*. New York: Grune & Stratton, 1972.

Elliott, R., & MacKay, D. Social competence of subnormal and normal children living under different types of residential care. *Journal of Mental Subnormality*, 1971, *17*, 48-53.

Enright, R. D., & Sutterfield, S. J. Treating the regular class child in the mainstreaming process: Increasing social cognitive development. *Psychology in the Schools*, 1979, *16*, 110-118.

Fenichel, O. *The psychoanalytic theory of neurosis*. New York: Norton, 1945.

Fine, M. Counseling with the educable mentally retarded. *Training School Bulletin*, 1969, *63*(3), 105-110.

Foss, G. Rehabilitation counseling with the mentally retarded: Professional practice. In P. L. Browning (Ed.), *Mental retardation: Rehabilitative counseling*. Springfield, IL: Charles C. Thomas, 1974.

Grossman, H. J. (Ed.). *Manual of terminology and classification in mental retardation* (1973 revision). Washington, D. C.: American Association on Mental Deficiency, 1973.

Hallenbeck, P. N., & Campbell, J. L. A conceptual framework for work adjustment training. In L. K. Daniels (Ed.), *Vocational rehabilitation of the mentally retarded*. Springfield, IL: Charles C. Thomas, 1974.

Halpern, A. S., & Berard, W. R. Counseling the mentally retarded: A review for practice. In P. L. Browning (Ed.), *Mental retardation: Rehabilitation and counseling*. Springfield, IL: Charles C. Thomas, 1974.

Heron, T. E. Maintaining the mainstreamed child in the regular classroom: The decision-making process. Journal of Learning Disabilities, 1978, 11, 210-216.

Horne, M. D. Attitudes and mainstreaming: A literature review for school psychologists. Psychology in the Schools, 1979, 16, 61-67.

Hutt, M. L., & Gibby, R. G. The mentally retarded child: Development, education and treatment. Boston: Allyn and Bacon, 1965.

Jakab, I. Psychotherapy of the mentally retarded child. In N. R. Bernstein (Ed.), Diminished people. Boston: Little-Brown, 1970.

Kaufman, M. E. Group psychotherapy in preparation for the return of mental defectives from institution to community. Mental Retardation, 1963, 1, 276-280.

Kaufman, M. J., Gottlieb, J., Agard, J. A., & Kubic, M. B. Mainstreaming: Toward an explication of the construct. In E. L. Myen, G. A. Vergeson, & R. J. Whelan (Eds.), Alternatives for teaching exceptional children. Denver: Love, 1975.

Mahoney, S. C. Observations concerning counseling with parents of mentally retarded children. American Journal of Mental Deficiency, 1958, 63, 81-86.

Mann, P. H., Beaber, J. O., & Jacobson, M. D. The effect of group counseling on educable mentally retarded boys' self-concepts. Exceptional Children, 1969, 35, 359-366.

Martin, E. W. Some thoughts on mainstreaming. Journal of Exceptional Children, 1974, 41, 150-153.

Maslow, A. H. Motivation and personality. New York: Harper & Row, 1954.

McMillan, D. L. Mental retardation in school and society. Boston: Little-Brown, 1977.

Mesibov, G. B. Alternatives to the principle of normalization. Mental Retardation, 1976, 14, 30-32.

Myerson, L. Somatopsychology of physical disability. In W. M. Cruickshank (Ed.), Psychology of exceptional children and youth. Englewood Cliffs, N. J.: Prentice-Hall, 1955.

Nadal, R. M. A counseling program for parents of severely retarded preschool children. Social Casework, 1961, 42, 78-83.

Nirje, B. The normalization principle and its human management implications. In R. E. Kugel & W. Wolfensberger (Eds.), Changing patterns in residential services for the mentally retarded. President's Committee on Mental Retardation, Washington, D. C., 1969, 179-188.

Porter, E. H., Jr. An introduction to therapeutic counseling. Cambridge: Riverside Press, 1950.

Rank, B. Adaptation of the psychoanalytic technique for the treatment of young children with atypical development. American Journal of Orthopsychiatry, 1949, 19, 130-139.

Rogers, C. R. Counseling and psychotherapy. Cambridge: Riverside Press, 1942.

Roos, P. Psychological counseling with parents of retarded children. Mental Retardation, 1963, 1, 345-350.

Rosenthal, R., & Jacobson, L. Pygmalion in the classroom. New York: Holt, Rinehart, & Winston, 1968.

Sarason, S. B. Psychological problems in mental deficiency (2nd. ed.). New York: Harper, 1959.

Sawrey, J. M., & Telford, C. W. Psychology of adjustment (2nd. ed.). Boston: Allyn & Bacon, 1967.

Servis, B., & Carpignano, J. L. Psychosocial aspects of physical disability. In J. L. Bigge (Ed.), Teaching individuals with physical and multiple disabilities. Columbus: Merrill, 1976.

Stacey, C. L., & DeMartino, M. F. Counseling and psychotherapy with the mentally retarded. Glencoe, IL: Free Press, 1957.

Sternlicht, M. Psychotherapy procedures with the retarded. In M. N. Ellis (Ed.), International review of research in mental retardation (Vol. 2). New York: Academic Press, 1966.

Sternlicht, M. The psychology of mental retardation: Issues and approaches. New York: Psychological Dimensions, 1978.

Szasz, T. S. The myth of mental illness. American Psychologist, 1960, 15, 113-118.

Thorne, F. C. Counseling and psychotherapy with mental defectives. American Journal of Mental Deficiency, 1948, 52, 263-271.

Throne, J. M. Normalization through the normalization principle: Right ends, wrong means. Mental Retardation, 1975, 13(5), 23-25.

Warren, S. A., & Gardner, D. C. Indices of increased interest in mental retardation. The Training School Bulletin, 1973, 70, 57-62.

Wolfensberger, W. Vocational preparation and occupation. In A. A. Baumeister (Ed.), Mental Retardation. Chicago: Aldine, 1967.

Wolfensberger, W. Will there always be an institution? II. The impact of new service models. Mental Retardation, 1971, 9, 31-38.

Woody, R. H., & Billy, J. T. Counseling and psychotherapy for the mentally retarded: A survey of opinion and practices. Mental Retardation, 1966, 4, 20-23.

Wortis, H. Parent counseling. In J. Wortis (Ed.), Mental Retardation (Vol. IV). New York: Grune & Stratton, 1972.

Zipperlen, H. R. Normalization. In J. Wortis (Ed.), Mental retardation and developmental disabilities (Vol. 7). New York: Bruner-Mazel, 1975.

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2 COUNSELING STUDENTS WITH LEARNING DISABILITIES

Denzil Edge, Carolyn Brown, and Joe H. Brown

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COUNSELING STUDENTS WITH LEARNING DISABILITIES

Denzil Edge, Carolyn Brown, and Joe H. Brown

Counselors are playing a greater part in the education of children with learning disabilities, becoming active rather than passive participants in the process of helping these children. Counselors are involved in intervention and programming decisions from referral through treatment and are interacting with teachers, psychologists, principals, parents, and students. Alternative programming decisions are constantly being considered for children with learning disabilities, and the counselor is becoming an integral part of the decision-making team. In assuming this role, the counselor has to be aware of the numerous changes in the field of educating children with learning disabilities. This chapter attempts to describe alternatives for interacting with professionals, parents, and students for the purpose of developing educational programs for children with learning disabilities. An Interactive Model for Counseling is described, numerous decisions that counselors face daily are outlined, and the interactive relationships established with professionals, parents, and students for the education of these students are discussed.

The Interactive Model of Counseling

The Interactive Model of Counseling Children with Learning Disabilities is based on relationships established among professionals, parents, and students. These relationships are analyzed and investigated for the purpose of developing educational programs for students experiencing learning disabilities. School and home settings are also utilized in teaching these children. A flow chart demonstrating these interactive relationships has been developed for the reader (see Figure 1). An explanation of these professional, parent, and student relationships follows.

Professional

Counselors play the role of interchangers. They are able to interact and work with any professional in the field of educating students. Counselors act as facilitators and negotiators for children in a particular school. This is more adequately demonstrated by examining a case where a child is experiencing

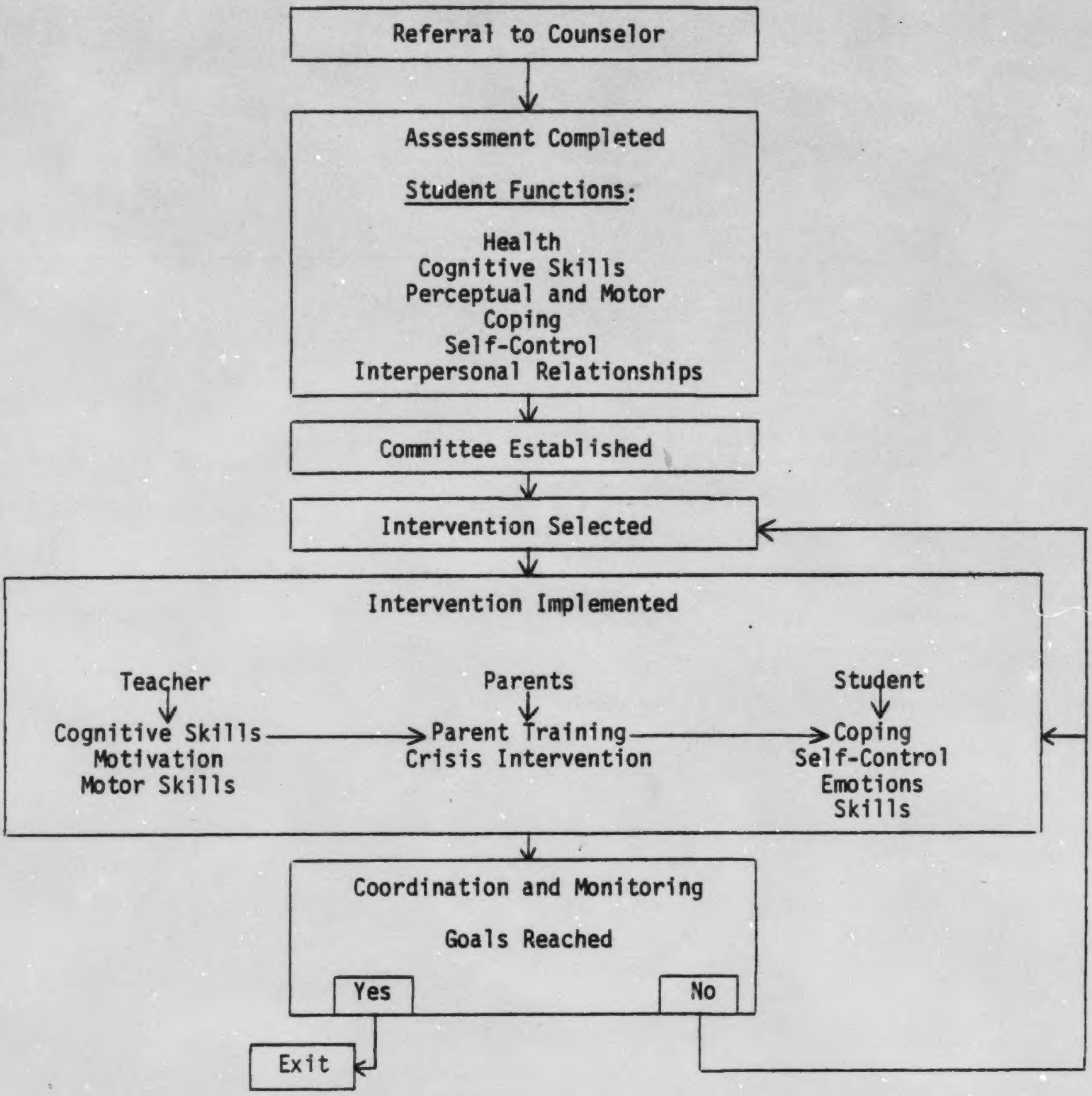
Referral to Counselor
Assessment Completed
Student Functions:
Health
Cognitive Skills
Perceptual and Motor
Coping
Self-Control
Interpersonal Relationships
Committee Established
Intervention Selected
Intervention Implemented
Teacher
Cognitive Skills
Motivation
Motor Skills
Parents
Parent Training
Crisis Intervention
Student
Coping
Self-Control
Emotions
Skills
Coordination and Monitoring
Goals Reached
Yes
No
Exit

Figure 1. Interactive Model of Counseling

problems. The numerous decisions that a counselor makes in processing a case are discussed below.

> *...Roger was referred to the counselor by his teacher. Roger was experiencing severe reading problems and had been acting out in the classroom. The counselor began the screening process. With the initiation of Roger's referral, a number of interactive processes occurred. The counselor contacted: (a) the parents for permission to evaluate Roger, (b) the psychologist for individual evaluation, and (c) the assessment team for educational evaluation. The principal and teacher were kept informed of the progress of the case and the School Based Admission and Release Committee's work. With the completion of the evaluation, the counselor played an integral part in the placement and programming decisions concerning the education of Roger.*

The counselor is a key facilitator and negotiator for the child within the Interactive Model. The counselor analyzes all the educational alternatives and becomes a member of the interactive team often referred to as the "School Based Admission and Release Committee." Members of this committee work closely in developing appropriate educational programs for children experiencing learning disabilities (Edge, Strenecky, & Mour, 1978).

Parents

Upon Roger's referral, the counselor contacted the parents for permission to evaluate Roger's educational, psychomotor, and emotional behaviors. This link in the Interactive Model is extremely important. The counselor protects Roger's due process rights through consultations with the parents who also become integrally involved in the process of educating their son. The parents are counseled regarding the evaluation process and educational alternatives available. The counselor is responsible for following through with the evaluation process and organizing meetings with the parents to discuss Roger's case.

Often, parent training or counseling is prescribed to help the child perform in the home environment. These strategies are developed to maximize the intervention programs in the school. The counselor is usually involved in working directly with the parents, or is responsible for assisting the teacher in implementing these programs. Again, the counselor becomes a key facilitator in developing educational alternatives for learning disabled children.

Students

Intervention with students experiencing learning disabilities should be the counselor's highest priority. Many students experience extreme frustration in coping with today's pressures for learning and have much to gain from interaction with a counselor who is trained to help them. (McLoughlin, Edge, & Strenecky, 1978).

In Roger's case, a great deal of help was needed. Often, he would break into tears, or destroy an object due to frustration over learning. People had told him that he was lazy, but he knew something was wrong. He needed help understanding this situation and the counselor was there to provide the needed support. Again, the counselor was a key person in the student's educational process.

Components of the Interactive Model of Counseling

In the Interactive Model of Counseling, the counselor plays a key role in coordinating the various services that children with learning disabilities require either in school or at home. The Interactive Model includes six basic phases for providing consistent service to children with learning problems. Each of these phases provides a mechanism for interacting with professionals and parents regarding children's needs. A case study approach is used here to demonstrate the Interactive Model of Counseling.

Referral to Counselor

The learning disabled child is typically identified first by the classroom teacher who makes a referral for assessment. Referrals can also come from others--the parents, the school principal, or the school nurse--but due to the great amount of contact, the classroom teacher is usually the first to suspect learning difficulties. As soon as the counselor receives the referral, collection of existing data on the child can begin and arrangements made for a meeting with the teacher to determine if further assessment is needed.

> *As stated earlier, Roger, an 8-year old third grader, was referred to the counselor by the teacher, Mrs. Richards, because of his difficulty with academic work. Roger was doing well in arithmetic, but having much difficulty with reading and spelling. Also, Mrs. Richards reported various behavior problems. After school one day she asked the counselor for suggestions on how to handle Roger. The counselor then set up a time to discuss the case further.*

Once a referral is made, the permission of the parents must be obtained in order for it to be processed. The counselor, as the coordinator in the Interactive Model of Counseling, serves as an advocate for the learning disabled child as well as for the parents. In fact, the counselor's work may sometimes begin with the child's parents because they are reluctant to start referral procedures. Many parents of learning disabled children have feelings of anxiety and guilt and think they are responsible for the child's problems. As a result, they may be fearful of a special assessment and hesitate to have their child receive special education services. In addition to feelings of guilt, the parents may resist special placement because they do not want their child to be labeled for life and because they are afraid that the special placement will be permanent. The counselor can help allay these fears and thereby keep the referral process moving forward. Once parents give permission, then, the next step is to assess and diagnose problem areas.

Assessment

For any given student, assessment should involve the child's skill in seven "child function" areas. These are: (a) health, (b) cognitive skills, (c) perceptual and motor skills, (d) coping, (e) self-control, (f) emotions, and (g) interpersonal relations. The responsibility for assessing the child's skills in these areas is shared by various people on the assessment team. For example, the classroom teacher can collect observation data on self-control, coping, and interpersonal relationships as well as work samples indicating the child's cognitive and motor skills. The teacher can also provide available achievement data and behavior checklists which indicate problem behaviors exhibited by the child.

The parents' role in assessment is to give developmental data and complete checklists indicating problem behaviors at home. Information about the child's visual and auditory acuity may be obtained from the nurse and speech teacher, respectively, and the psychologist may be asked to collect data concerning intellectual ability, perceptual skills, and emotional maturity. Where reading specialists or learning disabilities teachers are available for assessment purposes, they can administer diagnostic reading, arithmetic and spelling instruments, and determine specific academic skills and weaknesses.

In Roger's case, the counselor first had a conference with the teacher. Here, she determined that Roger's work in reading and spelling was poor, that he rarely finished any of it, and was easily distracted. She then observed Roger in the classroom and observed that his peer relationships were poor and that he tended to be rejected by other children. She also noted various aggressive behaviors, e.g., hitting other students and name calling. After observing Roger, she scheduled a conference with his parents to get an idea of his developmental history as well as his behavior at home. Mrs. Jones indicated that Roger was very slow in completing homework and that he disliked doing it. She reported that Roger was also very distractible and that he was easily frustrated. Her description of the end result of homework was: "We're both angry and upset before it's over." Mrs. Jones also agreed with the teacher, Mrs. Richards, that Roger had difficulty listening to instructions and often "forgot" to do what he was told, particularly if more than one task was assigned.

The counselor obtained all available achievement test data as well as the information on visual and auditory acuity determined by recent screening tests. She asked the teacher to complete a Walker Problem Behavior Identification checklist. The psychologist administered an intelligence test and a test of perceptual-motor abilities; the learning disabilities specialist administered the Peabody Individual Achievement Test, Keymath Test, and Utah Test of Language Development to determine Roger's skills in reading, math, and language. Also, the Detroit Test of Learning Aptitude was given to measure general learning aptitude as well as specific strengths and weaknesses.

Committee Work

After the assessment data have been obtained, the counselor's next task is to call a committee meeting that includes parents, the referring teacher, and other persons who are likely to be involved in the child's educational program. For example, if the child has a hearing impairment, it would be beneficial to include the speech and hearing teacher in the committee meeting. The interactive approach is emphasized as various persons give input and assist in the design of a satisfactory program. The committee meeting may begin with assessment reports which can be summarized and transferred to an assessment data form (see Appendix A). The data are then used, along with any additional information provided by the referring teacher, administrators, or parents. All pertinent information will be added to the assessment form.

> *The committee discussing the assessment results for Roger included the counselor, classroom teacher, learning disabilities specialist, speech teacher, and principal. At this time, all of the assessment data were discussed and a summary of the discussion was recorded. Specific assessment data discussed at the case meeting and the summary of results are found in Appendix A.*

In order to analyze the various roles that the counselor plays in helping with decisions and implementing program strategies, the reader is referred to the next section of this paper which describes the selection and implementation of intervention strategies.

Intervention Selected

Given the data concerning the child's strengths and weaknesses in each of the "child function" areas, the next step is to determine an appropriate intervention. Looking again at the assessment summary form, the committee will determine what needs are to be addressed in each child function area and how the plans will be implemented. The information on intellectual ability will provide an indication of the child's rate of learning. Academic skill levels will show what skills the child has mastered and the level at which instruction should be designed.

The perceptual and motor skills data will indicate whether or not the child has a specific learning channel (visual or auditory). Other data will indicate problem areas such as lack of self-control, inability to cope, deal with emotions, and relate to others. These data will be summarized according to strengths, weaknesses, and recommendations.

In selecting intervention strategies, the following specific questions need to be addressed:

1. What is the least restrictive environment in which the child can make satisfactory progress?
2. What specific educational approaches are warranted?
3. Is any special training or specialized work warranted for the family?

Determination of placement, individualized instructional programming, and family involvement will be outlined in the answers to these questions. Through the committee, the counselor becomes an advocate for the child.

Intervention Implemented

At this stage, the counselor needs to be aware of those techniques which can facilitate the implementation of the intervention strategies agreed to by the committee. An analysis of these content areas follows.

Health. Two areas which should be considered by the counselor in a health intervention plan are medical information and monitoring of treatment. Many children with learning disabilities are hyperactive and medication may be considered in the treatment plan. It should be noted, however, that there is conflicting evidence on drug effectiveness (Krippner, et al., 1973). Some researchers say continued use of such drugs as Ritalin results in more compliant behavior but does not lead to improved academic work (Ayllon, et al., 1975). Even so, there are cases where physicians will suggest medication and parents will follow the suggestion. In these cases, the counselor can help by explaining the use of the drugs to children (so that they do not see themselves as "sick") and by helping to monitor the effects of drugs on children at school.

Counselors may also be involved when an excessive intake of sugar is believed to cause excessive activity. A special diet may be suggested to the parents and the school nurse may even help design a menu. At the individual level, the counselor can explain to children how sugar affects their behavior (or teach parents how to explain this to children).

Counselors can often help parents with a system for monitoring their child's diet. Parents and children can keep a chart of what they eat for each meal or between meals. Once the chart has been completed, parents can note particular deficits (e.g., fruits and vegetables) and excesses (e.g., sweets) in the child's diet. The goal then becomes to increase the child's intake of nutritious food and decrease the amount of non-nutritious food (Stevens, Stevens, & Stoner, 1977).

Cognitive skills. The intervention for improving cognitive skills (academic skills) will be dependent upon the kinds of difficulties the child is experiencing, and instruction will need to take place at the child's level. Where possible, it is beneficial to involve parents since the program will be more effective if there is a cooperative effort between school and home. For example, the counselor can arrange with the parent to set a time for the child to complete homework. Or, the counselor can ask the teacher to send a note with the child instructing the parents about what should be completed.

If the child is exposed to more than one teacher, each teacher can note any special assignments. Parents could monitor the assignments to make sure they have been completed correctly. Then, when the child has completed the work, a special reward, such as T.V. time, food, or a game might be provided.

A variety of tutorial exercises can also be used by parents in remediating learning deficiencies. Flash cards with words and numbers can easily be used to increase both recognition and attention. Teachers can provide parents with appropriate cards for each child.

Perceptual and motor skills. The learning disabilities and physical education teachers may cooperate to help remediate gross motor difficulties. Also, behavioral techniques have been useful in ameliorating severe perceptual-motor disorders (Lahey, et al., 1977). Specifically, children that have severe problems with orientation, sequencing in copying words, mirror writing and reversals can be trained to improve writing and figure drawing through the use of tokens (traded in for pennies) and corrective feedback. The counselor can either provide such a training program or train other personnel to implement it.

If children have difficulty with fine and gross motor skills, they may be given models to practice these skills (Keat, 1974). The counselor, teacher, or parent can provide brief instructions to help children connect the model parts and praise them for following directions. If they have difficulty, the counselor, teacher, or parent can guide hands and fingers, but the children should finally be able to connect the parts without help. The counselor should praise the children once they are successful.

Coping skills and self-control skills. These areas are combined here since there is much overlap in the counseling techniques. Cognitive training is an approach which has been effective in inhibiting distracting stimuli and in helping children solve problems, inhibit excessive activity, and focus attention on completion of a task. Meichenbaum and Goodman (1971) describe cognitive training as modeling the desired behavior for the child; verbalizing it while the child does it; having the child do the task and verbalize it; and gradually having the child do the task while internally verbalizing the process. Douglas, et. al, (1976) used this approach to help children achieve

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better inhibitory control and to attend and plan better. They taught children to define the problem, consider several possible solutions, check work throughout and correct errors calmly, stick with the problem until everything has been tried, and finally pat themselves on the back for doing a fine job.

Birkimer and Brown (1979) demonstrated that the counselor can work with teachers to teach self-control skills to children. In this study, four elementary school students were taught to control their own behavior. Teachers initially posted a set of rules for the children. Next, teachers rated the children's behavior from 0 (low) to 10 (high), depending on how well they followed the rules. Children could trade their points (ratings) in for back-up reinforcers. After the behavior improved for three weeks, teachers asked the children to rate their own behavior. If their ratings were within plus or minus one point of the teachers' ratings, they received two bonus points, while children who differed more than one point lost two points. When the rating system was withdrawn, the children were still able to control their behavior.

Related to self-control are problem-solving skills where the child is asked to generate several possible solutions and evaluate them. D'Zurillan and Goldfried (1971) have found this technique to be effective with children. Their program includes five phases. In the orientation phase, the counselor teaches children to recognize common problems which require action to resolve. In the problem definition phase, children are taught to define the problem, identify the elements, and recognize any factors which may prevent its resolution. In the problem-solving phase, they are taught to generate alternative solutions to the problem. Here, counselors should encourage children to "brainstorm" as many alternatives as possible. In decision-making, the fourth phase, children are taught strategies for evaluating outcomes. Finally, in the verification phase, children are encouraged to select and try out the desirable alternative.

In many instances, learning disabled children are not motivated to complete the work. The teacher reports that a child never finishes homework and lacks interest in learning. At this point the counselor can serve as a coordinator to bring together two factors which are significant in motivating the child.

First, the material should be geared to the child's level, the counselor working with the teacher to ensure that this happens. Second, reinforcers for the child must be identified.

There are three ways to identify activities that are reinforcing to children. First, the counselor can meet with a child and ask what things s/he is interested in. Second, the counselor can observe the child during free time or recess to see what s/he enjoys doing. Third, the counselor can provide the teacher, parent, or child with a reinforcement menu and ask each of them to check which activities the child most prefers. An example of this follows.

Menu

	Don't like at all	Like somewhat	Like a lot
1. Foods			
a. cake	________	________	________
b. ice cream	________	________	________
c. gum	________	________	________
d. apples	________	________	________
2. Games			
a. checkers	________	________	________
b. Monopoly	________	________	________
c. UNO	________	________	________
d. jacks	________	________	________
e. puzzles	________	________	________
3. Activities			
a. baseball	________	________	________
b. painting	________	________	________
c. coloring	________	________	________
d. models	________	________	________
e. swimming	________	________	________
f. camping	________	________	________
g. T.V.	________	________	________

Once reinforcers have been identified, they can then be offered to the child contingent upon appropriate behavior. For example, the child can only go out and play or watch T.V. when an assignment has been completed. Such contingencies can often be written up in the form of a contract (Figure 3).

The data in Figure 2 demonstrate that only when Roger completed 80% of his assignments would he be allowed to watch one hour of T.V. The counselor in this case must ensure that all parties follow through with their part of the contract.

Effective Dates: From July 15 to July 30

We, the undersigned parties, agree to perform the following behaviors:

If Roger will complete 80% of his assignments each day	Then Roger's parents agree to allow Roger to watch T.V. for one hour.

Bonus: If Roger completes more than 80% of his assignments on four consecutive days, Roger's parents agree to let Roger invite one of his friends to stay overnight once.

Penalty: If Roger completes less than 80% of his assignments on three consecutive days, he will lose his weekend late-night privileges for one week.

Roger

Mr. and Mrs. Jones

Mrs. Richards (Teacher)

Ms. Price (Counselor)

Figure 2. Sample Contract

Emotions. It is not unusual for learning disabled children to have low self-esteem. This may occur for several reasons. First, these children are often aware that they are unable to perform (e.g., read or spell) at the same level as their peers and may sometimes be called "dumb" or "slow." Second, many of the problems typical of learning disabled children (e.g., hyperactivity or attentional problems) may cause them to receive more than a normal share of negative feedback, both from teachers and parents. After a while these children may begin to perceive themselves as "bad" or unable to please anyone. Strength bombardment, or "sock it to me," is a good technique to use with children who view themselves as inadequate. This is usually done in a small group where children take turns sitting on the "hot seat" while their peers "bombard" them with compliments and comments about things they do well and all of their positive characteristics. Also, a "strengths," "accomplishments," or "progress" chart can help children begin to look objectively at things they can do well. The counselor may also work with the teacher on "catching the child being good" and reinforcing the positive rather than the negative behavior.

A second typical emotion shared by learning disabled children is anxiety. Anxiety occurs for many of the same reasons as low self-esteem. Children may be putting forth effort but are still having difficulty completing tasks their peers can readily do. Or they may not be meeting the expectations of parents, peers, or teachers. One obvious way to decrease this anxiety is to gear assignments to childrens' level of ability. Relaxation training is another approach the counselor can try. Children learn how to relax the basic muscle groups and imagine pleasant scenes at the same time. Because relaxation and anxiety are incompatible behaviors, children can learn to replace anxiety with relaxation. Some counselors put relaxation instructions on tape (Keat, 1977) and these can be used by children without the counselor being present.

A third typical emotion of learning disabled children is anger. The difficulty they have inhibiting their behavior may result in a quickness to anger and a tendency to "act before thinking." The counselor can help teach children impulse control using the cognitive training approach described under self-control skills. This may begin with teaching children to hesitate before acting and then teaching them to "talk out" possible alternative behaviors and consequences. Imagery is also useful in teaching this--children may be asked to imagine a situation which would make them very angry, think about how they would typically react, and then figure out how they would like to react. The counselor can determine situations in which children show little control over anger by talking with them and observing them in the classroom or on the playground. These typical situations can be discussed and children asked to determine better ways of handling their anger.

The counselor can also teach learning disabled children constructive ways of dealing with anger. For instance, "I messages" allow children to express anger but have a much lower probability than aggressive behavior or name-calling of making the situation worse. Specifically, children learn a 2-part message to communicate angry feelings. They tell the person how they feel about the specific behavior exhibited and exactly how the behavior affected them. For example, when Roger becomes angry with George for flipping him on the arm in passing, he may say,"I get mad when you flip me like that. It hurts," rather than starting a fight with George.

Interpersonal relationships. Interpersonal relationships as described here include children's relationships with family as well as with peers. It is not unusual to find stress in families of learning disabled children and there are several reasons for this. Learning disabled children often are less responsive to directives, are more active, and have more problems with school work than normal children. Many parents become frustrated trying to help their learning disabled child because the process is slow; in addition, they may have difficulty understanding why their child can't remember or sit still. Various activities can be used to help parents understand such difficulties. For instance, talking in a very low voice to parents when there is a great deal of background noise may help them recognize the difficulty children experience when they can't screen out competing stimuli or have a hard time with auditory discrimination tasks. Asking them to read a passage where words run together, punctuation is absent, and letters such as p and q or b and d are reversed, helps them recognize the difficulties of children with visual discrimination problems. Similarly, writing with a string dipped in paint may help them become more aware of the difficulties children with fine motor problems experience. Activities such as these may also be useful with teachers.

Sibling rivalries are often seen in the families of learning disabled children. Learning disabled children tend to get a great deal of attention (e.g., assessment, specially scheduled parent-teacher conferences, or more help with school work). While this extra attention is necessary, it may create some resentment on the part of other children in a family. Parents often need to be taught to be sensitive to their other children as well.

Examples of other occasions when the counselor may need to intervene in family relationships are when the family is experiencing a problem (e.g., marital discord or inability to manage the child) which affects the progress of the learning disabled child. The counselor may then either provide consultation on child management or marital counseling, or refer parents to places where they can obtain these services.

Some learning disabled children have good family relationships but get along poorly with peers. In this case, the counselor needs to determine the reasons why such a child is not interacting well. Is the child exhibiting behaviors which should be decreased (e.g., obnoxious and aggressive behavior)? Is the child exhibiting positive social behavior too infrequently? Does the child know how to interact appropriately with peers? Counseling techniques obviously differ according to the specific problem behavior. If the child knows how to interact with other students but chooses not to do so, the counselor might work with the teacher to set up cooperative situations (e.g., have students work in small groups, changing the small group membership from time to time). Teachers might also reinforce students who wish to join or participate in the activities of the class.

On the other hand, if the child has few friends because of inappropriate interactions, negative behavior needs to be decreased and replaced with positive behavior. For instance, if the child is annoying to others, such behavior must be extinguished if new relationship skills are to be learned. "Time-out" can be a useful technique when children are harming others. Then, if children do not interact because they don't have the skills to initiate, maintain, and terminate a conversation, the counselor can teach conversational skills through brief instructions, modeling tapes, role playing, feedback, and actual practice.

Applying these various interventions to Roger's case, the counselor began first with health. Since Roger's health was good, no intervention was necessary. In the cognitive area, his intellectual ability was average, and his achievement scores were not low enough to warrant special placement. However, the reading diagnostic tests indicated that he had difficulty with decoding skills and that instruction should be geared toward second grade level rather than third. It was decided that the speech teacher would work with Roger on receptive and expressive language skills.

Other areas which required attention were Roger's coping skills, self-control, ability to handle strong emotions, and interpersonal relationships. Plans for improving skills in these areas were discussed and the results were recorded in Roger's Individualized Educational Plan (IEP). A copy of this is shown in Appendix B.

Monitoring Children's Progress

The assessment of a child's problem and the organizing of programs to help are extremely important. However, the main work begins when the intervention strategies are implemented. Monitoring of these intervention strategies to determine the child's progress is an essential element of the counselor's role. This aspect of the counselor's role is very time consuming and entails communicating with professionals and parents about the child's progress. The following suggestions are provided to the reader for the purpose of stimulating alternative ways of interacting with professionals in the monitoring of the learning progress of children.

Practical suggestions for professional-counselor interactions.

1. Observe the child's performance in the classroom, and keep a record of the child's academic and social behavior.
2. Assist the teacher in planning intervention strategies based on observed behavior.
3. Assist the teacher in understanding behavioral interactions in classroom and school environments.
4. Provide key people with brief written reports on the child's progress.
5. Conduct brief progress meetings on the child's progress.
6. Assist with the organization of parent conferences.
7. Conduct small group meetings with children and professionals for the purpose of demonstrating positive behavioral interactions.

8. Assist professionals with the development of written reports on the child's progress.

9. Provide direct consultation on procedures for increasing, decreasing, and maintaining behavior.

10. Provide direct consultation on physical or medical issues related to the child's progress.

Counselors can provide essential assistance to the professionals who organize and conduct parent conferences. The parent conference is a means through which the child's progress is reported. Meaningful data can be discussed and pertinent information conveyed to the parents. Often, professionals are not aware of the counseling techniques needed to conduct a parent conference. Therefore, it becomes the counselor's responsibility to instruct teachers, principals, and other professional educators in the correct procedures for conducting a parent conference. The following suggestions are provided to the reader for the purpose of stimulating alternative ways of conducting a conference.

Practical suggestions for conducting a parent conference.

1. Organize materials in advance of the conference and assemble them in clearly marked folders for identification purposes. Materials provided to the parents should be clear, free of grammatical errors, and easy to read.

2. Attempt to establish rapport with the parents prior to discussing the child's serious problem areas; identify a neutral issue for discussion.

3. State the purpose of the conference prior to beginning any meaningful discussion about the child; restate the purpose at the end of the conference.

4. Relax and take time conducting a conference; parents feel more at ease in a relaxed atmosphere.

5. Control verbal and facial expressions of disapproval or anger; parents can sense a counselor's feelings through nonverbal behavior.

6. Explain the child's progress in clear and simple language; educational terminology should be avoided as much as possible.

7. Keep on the subject at hand and do not discuss other children, allow parents to identify related topics for discussion. However, refer to the purpose of the conference if this occurs.

8. Develop at least one helping strategy in the conference; use the opportunity to provide verbal and direct support to the parents.

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9. Help the parents summarize the conference discussion; request that they take part in the summary.

10. Provide written follow-up about the conference; a one-page letter summarizing the discussion should be forwarded to the parents.

Summary

The Interactive Model of Counseling requires the counselor to play an active role in working with professionals, parents, and students. Children experiencing learning disabilities need a counselor/advocate to assist with the numerous problems that exist for them in school.

> *Roger's counselor assisted in monitoring his performance in the classroom and at home. Roger participated in small counseling groups in the school and the counselor assisted Roger's teacher in developing intervention strategies for the classroom. Every three months a brief progress meeting was held with the key supporters of Roger's progress. The counselor was the key initiator of these meetings. Also, follow-up checks were recorded on Roger's behavior at home. The parents were extremely helpful in providing the information, and it helped the professionals understand Roger's progress from a broader perspective.*

Counselors are taking a larger role in the education of children with learning disabilities. Professionals, parents, and students are becoming the counselors' clients. Counselors are no longer insular--they are becoming integrated into the mainstream of educating handicapped children.

REFERENCES

Ayllon, T., Layman, D., & Kandel, H. A behavioral-ed/al alternative to drug control of hyperactive children. Journal of Appropriate Behavior Analysis, 1975, 8, 137-146.

Birkimer, J. C., & Brown, J. H. The effects of student self-control on the reduction of children's problem behaviors. Behavioral Disorders, 1979, 4, 131-136.

Douglas, V., Parry, P., Marton, P., & Garson, C. Assessment of a cognitive training program for hyperactive children. Journal of Abnormal Child Psychology, 1976, 4, 389-410.

D'Zurillan, T., & Goldfried, M. Problem solving and behavior modification. Journal of Abnormal Psychology, 1971, 78, 107-129.

Edge, D., Strenecky, B. J., & Mour, S. I. Parenting learning-problem children: An Education Perspective. Columbus, OH: The National Media and Materials Center for the Handicapped, 1978.

Keat, D. B. Fundamentals of child counseling. Boston: Houghton-Mifflin, 1974.

Keat, D. B. Self-relaxation program for children (tape 2). Harrisburg, PA: Professional Associates, 1977.

Krippner, S., Silverman, R., Cavalla, M., & Healy, M. A study of hyperkinetic children receiving stimulant drugs. Academic Therapy, 1973, 8, 261-269.

Lahey, B., Busemeyer, M., O'Hara, C., & Beggs, V. Treatment of severe perceptual-motor disorders in children disagnosed as learning disabled. Behavior Modification, 1977, 1, 123-140.

McLoughlin, M. A., Edge, D., & Strenecky, B. J. Perspective on parental involvement in the diagnosis and treatment of learning disabled children. Journal of Learning Disabilities, 1978, 11(5), 291-296.

Meichenbaum, D., & Goodman, J. Training children to talk to themselves: A means of developing self-control. Journal of Abnormal Psychology, 1971, 77, 115-126.

Stevens, L. J., Stevens, G. E., & Stoner, R. B. How to feed your hyperactive child. New York: Doubleday, 1977.

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APPENDIX A

Assessment Data Form

Name *Roger Jones* Age *8* Grade *3-8*

Teacher *Mrs. Richards*

In each of the following areas, specify both the weaknesses and strengths, if appropriate.

I. HEALTH

Auditory Acuity *within normal limits*

Visual Acuity *20/20 both eyes*

General Condition of Health *good*

II. COGNITIVE SKILLS

Intellectual Ability *Average range. Full scale IQ 98; Verbal 88; Performance 109 (Low in Information and Vocabulary, good in Object Assembly).*

Reading Skills *Word recognition 2.2; Comprehension 2.4; 1-1/2 years below grade level*

Arithmetic Skills *3.6 (Keymath); 3.5 (PIAT)*

Spelling & Writing Skills *2.8 in Spelling; Writing Sample Okay*

Language Skills *Receptive: poor picture vocabulary; poor in general information. Expressive: poor expression, low scores in sentence imitation and grammatic completion, poor articulation (difficulty with th's and r's), poor sentence structure*

III. PERCEPTUAL & MOTOR SKILLS

Auditory Perception *Auditory memory poor; difficulty in retrieval*

Visual Perception *poor picture vocabulary; poor on pictorial absurdities; problems in visual channel (reception)*

Visual-Motor Skills *adequate*

Fine Motor Skills *adequate*

Gross Motor Skills *adequate*

IV. COPING SKILLS

Ability to Solve Problems *poor (high level on acting-out scale of Walker)*

Motivation Level in the Classroom *low*

V. SELF-CONTROL

Attentional Skills *low (high score on distractibility)*

Ability to Inhibit Distractions *poor*

General Activity Level *high*

VI. EMOTIONS

Ability to Handle Strong Emotions (e.g., anger) *acts out when angry*

Level of Self-Esteem *low, according to Walker*

VII. INTERPERSONAL RELATIONSHIPS

Family Relationships *lot of family conflict, according to mother*

Peer Relationships *poor*

Summary

Strengths	Weaknesses
good visual-motor skills	*Poor language skills:*
good perceptual organization	*receptive (low in general information and picture vocab.)*
good health	*expressive - can't express himself well*
average intelligence	*Behavior:*
good (average) math skills	*low frustration tolerance*
	distractible
	poor peer relationships
	low motivation
	high level of acting-out behavior

Recommendations

Reading:

Emphasize decoding skills, gear instruction to second grade level

Speech teacher will work with him on language skills

Regular classroom placement with resource room availability for reading and spelling

Behavior:

Self-control training

Social skills training

Contingency management

Impulse control training

Parents:

Suggest parent education group

APPENDIX B

Individualized Education Plan

Name ______________________ Date ______________________

AREA	GOALS	ACTIVITIES	PERSON(S) RESPONSIBLE	MONITORING TIMES
Reading	To improve decoding skills.	Give phonics inventory to determine Roger's mastery level. Then teach the skills he doesn't have. Gear material at lower level (2nd grade).	Resource Room Teacher	3 months
Language	To improve articulation (th's and r's).	Articulation Training.	Speech Teacher	3 months
	To improve skills in following simple directions.	Give Roger simple directions. Provide reinforcement if completed accurately. Gradually increase the number of tasks given.	Teacher	3 months
	To increase fund of general information.	Take field trips in neighborhood/community; discuss observations.	Teacher and Parents	3 months
	To improve classification	Give Roger matching exercises - colors or shapes.	Teacher and Parents	3 months
	To improve expressive language	Describe objects, tell stories about pictures, name pictures to improve picture vocabulary.	Resource Room Teacher	3 months
Coping	To increase the number of assignments completed by 50%.	Assignments will be shorter and will be geared to Roger's instructional level. He will receive tokens for each assigment turned in and he can trade them for back-up reinforcers.	Teacher will dispense tokens; parents will help provide back-up reinforcers.	3 months

APPENDIX B (Cont.)

AREA	GOALS	ACITIVITES	PERSON(S) RESPONSIBLE	MONITORING TIMES
Coping (cont.)	To decrease acting-out behavior (disruptive or aggressive behavior) in the classroom by 50%.	Problem-solving and cognitive training will be combined. The cognitive training will help Roger inhibit impulsive behavior and the problem-solving will help him learn that there are several alternative ways to behave in any given situation.	Counselor	3 months
Self-Control	To increase time on-task to 80% level.	Praise will be given for attending behavior; tokens will be given for blocks of time (15 min.) that Roger stays on task. (Blocks of time will gradually be increased.)	Teacher	3 months
Emotions	To learn how to handle anger appropriately (inhibit impulsive and aggressive behavior).	The cognitive training and problem-solving techniques described under "Coping" will also be used for anger control. Teach Roger how to express anger with "I messages."	Counselor	3 months
Interpersonal Relationships	To improve parenting skills of Roger's parents.	Refer parents to school's Parent Education Program.	Counselor	3 months
	To reduce family conflict.	Determine receptiveness of parents for family counseling and give them referral sources.	Counselor	3 months
	To improve Roger's social skills	Make contract with Roger to reduce aggressive behavior (hitting and name calling). Place Roger in group to learn appropriate social skills (how to start and maintain conversations, express anger, give compliments, solve interpersonal problems).	Counselor	3 months

3 COUNSELING THE EMOTIONALLY DISTURBED

Donna R. Eyde

Donna R. Eyde is Director of Educational Therapy at the Nebraska Psychiatric Institute and holds joint appointments as Assistant Professor at the University of Nebraska Medical Center and the University of Omaha. She is a graduate of the University of Missouri-Columbia (1977) and has taught courses in special education at the University of Missouri and William Woods College in Missouri. Recent professional interests and experiences include a focus on emotionally disturbed early adolescents and autistic children and youth.

Dr. Eyde has published several articles and presented a number of papers nationally and internationally on mental retardation and emotional disturbances. She is the Associate Editor of the Journal of Behavioral Disorders, Associate Editor of a new monograph, Career Education for the Behaviorally Disordered, Series Editor for Monographs in Behavior Disorders, and holds offices in local, state, and national organizations for exceptional children. Current consultative activities include respite programs for parents of emotionally disturbed, re-education of parents of autistic children, prescriptive play for complex handicapped children, and alternative living arrangements for complex handicapped. Most recently she conducted the first Nebraska Symposium on Educating Early Adolescents and a preconvention institute for APA school psychologists on school-based techniques for intervening with emotionally disturbed students.

COUNSELING THE EMOTIONALLY DISTURBED

Donna R. Eyde

This chapter focuses upon a number of issues and concerns relative to the special counseling needs of emotionally handicapped children and youths. Given the prevalence of mental health needs among the school-aged population and current federal and state regulations relating to the counseling needs of special students, the role of the counselor is greatly expanding. The new three "C's" of the school counselor role include mental health Consultant to families, school personnel, and community agencies; Collaborator or case manager of multidisciplinary teams in planning and implementing individualized educational programs (IEPs); and Conceptualizer of behavioral disorders in terms of location of the problem, severity of the problem, and needed interventions to resolve the problem. A number of counseling techniques applicable to this population are reviewed including developmental group counseling; anticipatory counseling for stress management and suicide prevention; individual counseling activities relative to specific concerns such as behavior management, life-space interviewing, affective education, leisure education, self-control, relaxation, and biofeedback training; peer counseling; and parent counseling. Personal qualities which enhance the counseling process are discussed as well as the counselor's role as mediator and advocate. It is concluded that a mental health guidance curriculum should be developed and that the teaching responsibility be cooperatively shared by both regular and special educators and school counselors. Lastly, it is proposed that future efforts focus intensively upon the development and implementation of a career education/work therapy program for all school-aged emotionally handicapped learners.

State of the Art

Counseling the Exceptional

Few areas of professional endeavor have been as characteristically reactive to social, political and educational concerns as the field of school counseling. Few human service professionals have been expected to function in such a variety of roles and meet such a variety of individual learning needs with such variable support and professional preparation. In the past, the school counselor has been expected to provide appropriate counseling services along a continuum of student, teacher, and community needs ranging in scope from maintaining mental health to preventing mental illness. Currently, school counselors are being assigned major teaching responsibilities relating to the social-emotional development of all students within the school, handicapped and nonhandicapped alike.

In view of the generally escalating demand for counseling services, it is not entirely unexpected that school counselors should be given expanded responsibilities within the school and within special education. However, it is surprising that so little preservice or inservice training relative to the needs of exceptional students is included within counseling education. Nearly 20 years have passed since Hunt (1960) observed that the training of counselors is frequently inadequate to allow for either acceptance or understanding of the exceptional child; but many counselors are still either unfamiliar with the special counseling needs of exceptional students and their families or with meeting those needs, which they frequently view as exceeding the limits of their current responsibilities (Cormany, 1970; Hansen, 1971; Patterson, 1969; Wyne & Skjei, 1970).

If school counselors have maintained a more or less "hands-off" posture toward special education students, in all probability this is because neither their training nor on-the-job experiences have prepared them for increased involvement. Special educators have been excessively territorial about their students and have offered little in the way of information or encouragement to counselors.

The passage of PL 94-142, The Education of All Handicapped Children Act of 1975 (Office of Education), has by mandate increased the required disturbed, the practices to be discussed have relevance for other groups of handicapped learners who are similarily at risk to experience deviant and/or delayed social emotional development in or out of the mainstream.

Who and Where are the Emotionally Disturbed?

The term "emotionally disturbed," according to Reinert (1972), appeared in the professional literature nearly 75 years ago. Since that time, the term has served a variety of masters for a variety of purposes but there is still no universal agreement on what the term means. The trend in special education has been to abandon most terms which smack of the medical model, such as "emotionally disturbed," and to substitute descriptors with greater educational relevance, such as "behaviorally disordered" (Graubard, 1973). However, even the educators' term "behaviorally disordered" fails to focus adequate attention on the important counseling needs of students with this handicapping condition. Emotionally disturbed students are ones who are "disturbing" to themselves and/or to their educational environment. Reinert (1976) describes these learners as "children in conflict." For purposes of continuity, this chapter will use all three terms--emotionally disturbed, behaviorally disordered, and children in conflict--when referring to students who are disturbing to themselves or their environment. The child in conflict is one "whose manifested behavior has a deleterious effect on his personal or educational development and/or on the personal or educational development of his peers" (Reinert, 1976, p. 6). The consequences of the conflict or disturbance will vary considerably from student to student; from environment to environment; and in severity, treatability, and prognosis. Recent census figures indicate that approximately 1,500,000 school-aged children are currently identified as falling within the category of health problems labeled emotional disturbances (Karel, 1979).

Educators have tended to define the degrees of disturbance in relation to the types of educational services needed. Thus students may be defined as mildly, moderately, or severely disordered depending on their placement among service alternatives and their need for special services. Kelly, Bullock, and Dykes (1977, pp. 316-317) outlined three broad service categories used most often in schools to classify behaviorally disordered scope of counseling services for handicapped students with the result that now planning for handicapped learners can be truly a shared responsibility. Several significant educational principles are made explicit in this piece of legislation. The regulations which have greatest impact on school counseling functions are those requiring the "least restrictive placement" of exceptional students and the use of "related" services to maximize their learning opportunities.

The principle of least restrictive alternative placement implies that handicapped students may not be segregated inappropriately and should be educated with their nonhandicapped peers whenever practicable (Turnbull, 1978). Schools should provide a continuum of special education service options so that students with mild to moderate handicaps may receive all or a part of their education in the "mainstream" of normal school activities.

The practice of "least restrictive placement," like so many good ideas, may prove to be a mixed blessing. Whereas handicapped students should be given the right to be educated in the mainstream with their nonhandicapped peers, without appropriate support services many are at risk to fail in the mainstream and may develop significant emotional problems secondary to their identified handicap. Many handicapped students will require special school counseling services in order to survive the circumstances and characteristics of mainstreamed education. Perhaps this is the underlying reason for including school counselors in the inventory of needed, related support services. If students, handicapped and nonhandicapped, are going to benefit from the new ethics of special education, then general and specific involvement of school counseling is imperative. Conversely, if school counselors are going to assume greater responsibility for meeting the social and emotional needs of all students, then special educators must increasingly share their expertise with counselors as well as their sense of ownership of handicapped education.

The purpose of this chapter is, hopefully, to increase understanding of the shared responsibility for meaningful and maximally appropriate education of handicapped learners. While the primary focus of this chapter is on the active counseling needs of students identified as emotionally learners. These include the following:

1. Mild behavioral disorders. Refers to children or youths who can be adequately served by the regular classroom teacher and/or other school resource personnel through periodic counseling and/or short term individual attention and instruction.

2. Moderate behavioral disorders. Refers to students who are able to remain in their home schools but require intensive help from one or more specialists and from mental health clinics, diagnostic centers, and other special services agencies.

3. Severe behavioral disorders. Refers to children and youths whose difficulties require assignment to a special class or to a special school.

Kelly, Bullock, and Dykes (1977) reported considerable data relative to teachers' perceptions of children and youths who manifest these three types of disorders. They reported that the mean percentage of students perceived as experiencing behavioral problems was 20.4%, with 12.6% assigned to the mild grouping, 5.6% to the moderate category, and 2.2% to the severe category. Approximately two males for every female were perceived as being behaviorally disordered and two black students for every white student, grades kindergarten through seven. No significant racial differences were evident between grades eight through twelve.

Although the Kelly, et al., study reported on the perceptions of classroom teachers of the frequency of behavioral disorders, their percentages are remarkably close to the figures released by the Joint Commission of the Mental Health of Children. The Commission reported that 2% of the nation's school population are severely emotionally disturbed, another 8-10% are disturbed to the point of needing some type of assistance from a mental health worker, and up to 30% have some form of school maladjustment (Glidewell & Swallow, 1969). Bower (1960) stated that at least 10% of all school-aged children are seriously handicapped in their learning because of emotional problems. Kirk (1972) stated that anywhere from 2% to 22% of the school population exhibit emotional and/or behavioral problems. Overall projections indicate that without interventions, emotional disturbance will incapacitate more people than all other health problems combined (Dimick & Huff, 1974). Of the students who need special help, only 2-4% of the population will be referred to an out-of-school setting for help (Hyde, 1975; Kicklighter, 1976). These figures clearly indicate that with or without a federal mandate, students in need of special counseling will not receive it if school counseling does not expand its functions or if new staffing patterns are not developed to meet these mental health needs.

Counseling the Emotionally Disturbed

One way to conceptualize counseling services which could meet the reported mental health needs of the school-aged population would be to view the mental health of a student as a "living interaction that changes with adjustment resources and stress" (Reinert, 1976, p. 7). In this view, most children with adequate development, who can more or less accommodate environmental stresses, would fall within the category of mentally healthy. Disturbance and its subsequent need for attention may be perceived as a relationship between the student's reservoir of adaptive responses and changing environmental demands. This type of conceptualization defines both the direct and indirect counseling services needed by the emotionally disturbed learner. Marmor and Pumpian-Mindlin (1950) outlined the relationship that develops between the adjustive resources of an individual and the degree of stress under which he/she functions. These relationships and their potential application to counseling categories of disorders in children are depicted in Figure 1.

There are a number of important functional implications for direct and indirect counseling activities in relationship to the severity of the behavioral disorder evident in Figure 1.

Good mental health. Approximately 70% of school-aged children fall in this category based on current prevalence rates for mental illness. The counselor's primary responsibility to this group is preventive in nature and focuses on group and individual activities within the school and within the community which promote productive, adaptive responses to problems of everyday living in a complex society. The counselor functions almost as a mental health educator, developing and disseminating information relative to normal growth and development and sensitizing teachers and parents to signs of potential social-emotional problems. It

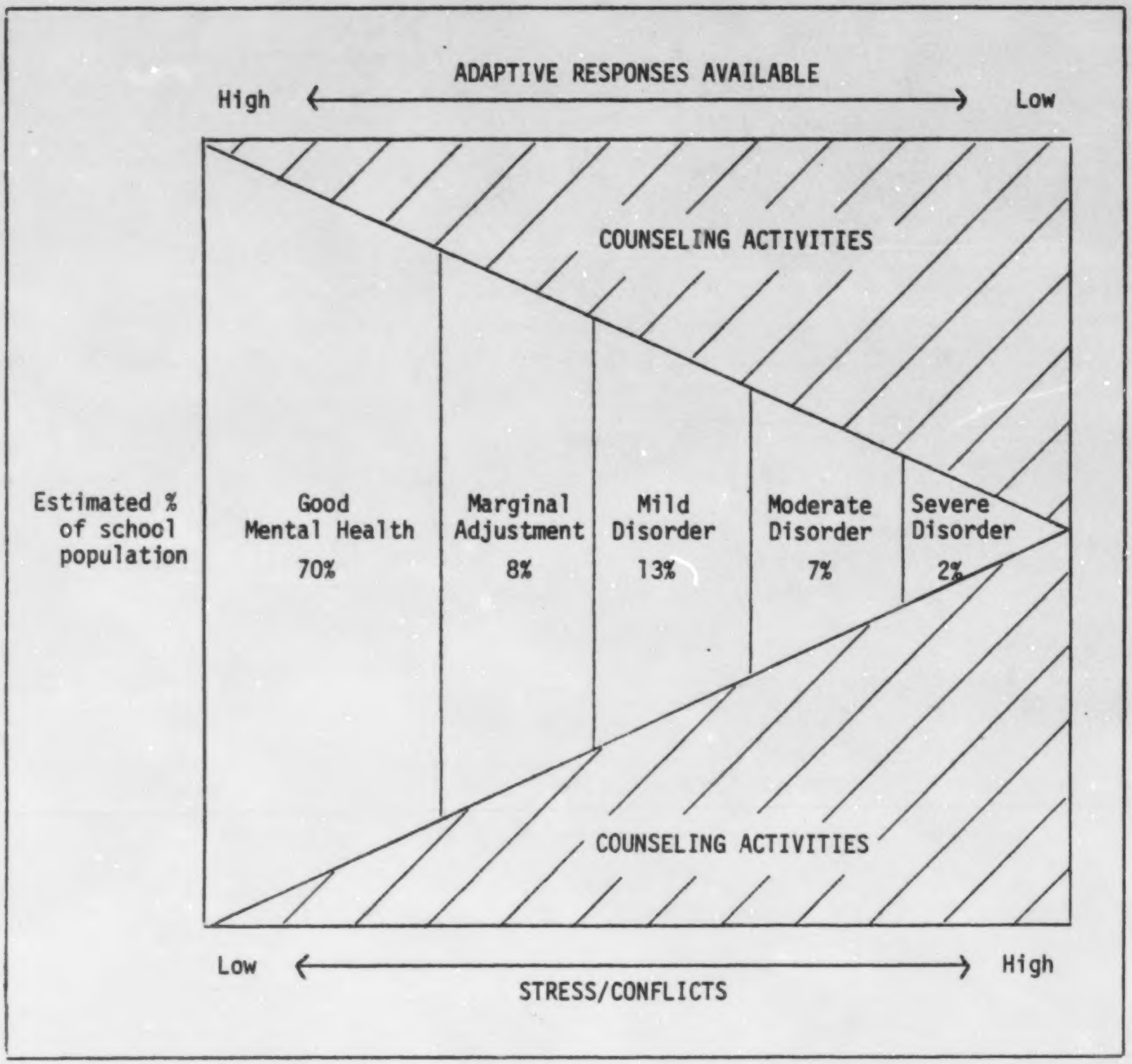
ADAPTIVE RESPONSES AVAILABLE
High
Low
COUNSELING ACTIVITIES
Estimated % of school population
Good Mental Health
70%
Marginal Adjustment
8%
Mild Disorder
13%
Moderate Disorder
7%
Severe Disorder
2%
COUNSELING ACTIVITIES
Low
High
STRESS/CONFLICTS

Figure 1. Counseling functions in relation to severity of conflicts, adaptive responses available, and degree of stress in environment.

is in this capacity of a mental health educator that the counselor functions as a curricular advisor, teacher trainer, and parent educator.

Marginal adjustment. The marginally adjusted student represents approximately 8% of the student population who are at high risk for developing conflicts. The counselor functions as a developmental specialist for this group of students. The counselor's activities include selecting instructional activities and structuring learning experiences in both the school and the home which will enable the learner to acquire those adaptive coping skills which will facilitate socio-emotional development. The counselor may work with the child directly or with the child's teacher to identify specific skill-deficits and design activities which will encourage the acquisition of needed skills.

Mild disorder. Students with mild behavior disorders can be adequately helped by specific consultation with the classroom teacher and/or resource personnel and through a variety of nonobtrusive intervention techniques. The counselor generally works closely with teachers to design remedial and/or classroom management programs for problem areas. Generally the behaviors in need of remedial attention can be grouped under the headings of affect, anxiety, and impulse control. Problems stemming from low self-esteem, feelings of inferiority, poor peer relationships, negativism, depression, and shyness may be viewed as problems of affective development. Anxiety has many origins and many expressions: Excessive fearfulness, low willingness to risk, daydreaming, overdependency, and defensiveness are a few of the behaviors which are at times characteristic of the anxious student. Impulse control problems represent the most disruptive classroom expressions of mild behavior disorders, ranging from inability to pay attention to the learning task to extreme aggressive reactions to classroom demands.

Moderate disorder. Moderately behavioral-disordered students have many of the same conflicts as those in the mild category, but the intensity and frequency of particular problems are greater. These students require help from one or more mental health specialists. The counselor's role becomes one of coordinating services in the community and school for the child and his/her family. Any direct intervention by the school counselor is primarily therapeutic in nature and may involve numerous individual counseling sessions which are usually coordinated with the activities of the outside mental health specialists.

Severe disorder. Severely behavioral disordered students usually require assignment to a special class or school. The counselor's function is to make appropriate referrals and provide liaison between the various servicing agencies, the school, and the family. Generally, the counselor does not counsel the student directly since the particular conflicts necessitate more specialized intervention from a psychiatrist, clinical psychologist, or mental health treatment team. The liaison function of the counselor is nonetheless of prime importance since the successful reintegration of the student into the community and/or school depends upon the care and professional concern of the counselor as a liaison worker.

One last observation is in order before leaving discussion of the counselor's role with emotionally disturbed/behaviorally disordered students. Experience has shown that the greater the severity of the emotional problem, the more areas of the child's life will be affected and the more resources will be needed to serve the student adequately. Whereas the degree of direct involvement of the school counselor becomes proportionately less as the severity increases, counselors should not forfeit their ownership of the child. Conversely, counselors should not try to serve the more disturbed child all by themselves without seeking outside help.

It is important to keep in mind that adjustment lies along a continuum and that each child's continuum of adjustment is unique. The role of the school counselor is to aid each individual learner, handicapped and nonhandicapped, along his/her continuum of adjustment toward optimal and meaningful functioning.

Service Delivery

While the conceptual model described in the preceding section may have general utility for determining various counseling functions, specific school counseling services for the emotionally disturbed student may

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be further described in terms of indirect and direct service delivery.

Indirect Services

At least three supportive service activities can be identified. These make up the new "C's" of indirect service: (1) the counselor as a mental health consultant to families, teachers, and other school personnel; (2) the counselor as a collaborator or case manager of a team in the individualized education program (IEP) planning process; and (3) the counselor as a conceptualizer of problem behaviors in terms of loci, severity, and needed services. Each of these categories of indirect counseling service will be considered in turn.

The Counselor as a Consultant

It has become nearly axiomatic in educational circles to note that the school counselor will have major responsibility for counseling, consultation, and coordination (ACES-ASCA, 1966, 258-259). These activities are undertaken with an end-in-view to prevent, detect, and/or remediate deviant or delayed socio-emotional development and to enhance the learning abilities of students who are experiencing learning problems. Unfortunately, the degree to which school counselors are actually performing general consultation duties has not kept pace with the amount of literature devoted to the topic in professional journals (Kahnweiler, 1979). Apparently, elementary counselors have been more willing to function in the consultation role than have secondary level counselors. Nonetheless, many individual counselors still express confusion relative to the consultative process (Kahnweiler, 1979).

Consultation to teachers, families, and other pupil personnel in the school or cooperating agencies concerning emotionally disturbed students means investing directly in teacher or parent change so that a better match can be obtained between the learner's developmental needs and the learning environments (Meyers, Parsons, & Martin, 1979). In this sense, changing the student's behavior becomes a secondary goal. The growth and development of any child depends upon the manner in which he/she interacts with the environment and upon the way the environment interacts with him/her. The failure to establish optimal environments in the home or classroom usually stems from teacher(s)/parent(s) lack of information, lack of necessary skills, lack of confidence in skills, and/or lack of objectivity (Caplan, 1970). Consultative service thus involves working with teachers or parents to determine which of these four categories is operative.

Lack of information. Consultation techniques are suggested after the nature of the problem is delineated. For example, a decision is made to integrate an emotionally disturbed elementary-aged child into a regular classroom. The receiving teacher has had little experience with this population and is very apprehensive. What can the counselor-consultant do? Consultation in this case consists of providing as much information as possible. One step in the process would be to provide reading material. A second step could be arranging for the teacher to visit another program which is known to be effective in dealing with emotionally disturbed learners. A third step should be follow-up discussion relative to the causes and treatment of emotional disorders. As part of this discussion, the consultant should provide some informational bridge between the teacher and the specific child in question. Parents as well as teachers often draw erroneous conclusions about "deviant" behavior because they lack sufficient knowledge regarding variations in the developmental process.

Lack of skills. Often the teacher or parent is knowledgeable about human growth factors, but each may lack the skills to actualize this knowledge in relationship to emotionally disturbed learners. Since special education consultation focuses on obtaining the best environmental match in the learning process, the consultant needs to be aware of the wide range of techniques available to observe systematically the environmental and interactive factors in the classroom or home (Amidon & Simon, 1965; Flanders, 1970: Ginott, 1972, Gordon, 1974).

One important consultative goal is to increase teachers' and parents' skills in systematic observation. A second goal is to help them develop skills for effective intervention in the environment based upon what has been observed. Schmuck and Schmuck (1974) and O'Leary and O'Leary (1976) emphasize detailed intervention plans based upon systematic observation of classroom behavior. Recently Brophy and Good (1970) developed a system for studying teacher-child dyadic interactions which enables one to focus specifically on the relationship between teacher and child. Spaulding (1967) devised a set of instruments which examine the relationship between children's coping behaviors and teachers' teaching styles. These measures provide information about students' behavioral styles by classifying behavior in various categories as an aid to observation. Some of these categories are aggressive behavior, negative attention-getting, manipulative behavior, controlling and directing others, and oppositional behavior. While these systems provide objective measures of the students' social-emotional behaviors in the class while simultaneously focusing on how the teacher interacts in relation to these behaviors, they also have potential utility for understanding parent/child interactions.

After developing observational skills, the next step is to aid the teacher or parent to design appropriate or optimal learning tasks for a given situation. Such nonevaluative feedback to increase the teacher's or parent's awareness of act-actor dynamics in the classroom or in the home is a potentially important consultation procedure. An emerging body of data suggests that appropriate consultation can result in significant reductions in classroom management problems with concomitant changes in classroom behaviors of students (Meyers, Parsons & Martin, 1979). It would be reasonable to assume that similar results could be achieved with disruptive behaviors in the home as well.

Lack of confidence. The front line teachers in schools today are challenged constantly by the learning problems that the mainstreamed exceptional child presents; they are bombarded with technological literature on how to teach; they are overwhelmed by new laws which seem to leave paperwork oceans in their wake; and, lastly, they are told with increasing frequency that they are doing a rotten job. It is little wonder that the ego strength of many teachers is at a low point. The teaching process is largely one of judgments. One of the functions of a counselor-consultant may be to provide sympathetic support to battered teachers so that they retain confidence in their ability to teach and deal with their students. Parents, too, experience this condition and at times may need only confirmation from the counselor that they are heading in the right direction in order to function effectively.

Lack of objectivity. It is difficult when working with emotionally disturbed children to maintain proper professional distance from the student so as to make objective decisions regarding that student's needs. Caplan's (1970) efforts to define lack of objectivity provide strong support for the role of the special education counselor as a consultant. Often values and attitudes get in the way of professional teaching. This group of learners in particular has a way of "hooking" a teacher into pathological or nonproductive interactions. The consultant can help teachers to maintain objectivity by defining problems in environmental/behavioral terms linked to intervention strategies--not linked to individual personalities or to individual acts.

Consulting with teachers and parents of emotionally disturbed children is a difficult and delicate task. In order to be successful, it requires the fullest expression of his/her caring capacity. Moreover, given current and projected case loads of both elementary and secondary counselors and the influx of exceptional children with exceptional counseling needs, consultation functions will become increasingly important.

The Counselor as a Collaborator and Coordinator of IEP's

The challenges and task demands inherent in implementing PL 94-142 clearly necessitate increased communication among professionals, including the school counselor. Each counselor must first become knowledgeable of the law, and of its intent and potential. The crux of PL 94-142 is the requirement for provision of appropriate instructional services to handicapped learners. The Individualized Educational Program (IEP) is a blueprint or description of how and by whom these services will be rendered. The development of the IEP must be carried out in accordance with specific due process guidelines. Minimally, the IEP must contain a statement of the child's current level of functioning; a statement of annual goals; statements of short term objectives; a statement of specific educational services needed; a description of the extent of time the child will participate in regular programs; a list of the individuals who are responsible for implementation and the objective criteria for evaluation; and evaluation procedures and schedules for determining if the goals are being achieved. Sproles, Panther, and Lanier (1978) observed that PL 94-142 with its accompanying requirements for the IEP places school counselors in a pivotal position to (1) plan and coordinate a variety of services for both handicapped children and their families; (2) plan and coordinate integration of handicapped children into the mainstream of regular education; (3) involve parents meaningfully in all phases of their child's education; (4) maintain detailed and relevant records of a child's progress; (5) monitor the IEP to ensure that each handicapped child receives an appropriate education; and (6) act as advocate within the system for additional services when needed.

The potential broadening of the counselors' functions in this way places them at the very core of special education service delivery. While the central position of the counselor is important in the education of all handicapped students, it is pivotal in the educational management of plans for the emotionally disturbed learner. Given the nature of the handicapped, school counselors are the most qualified personnel to collaborate, interpret, and manage implementation of the IEP. Sproles, Panther, and Lanier conclude that the process of case management will be far more effective if the school counselor's efforts "are preventive rather than remedial, ongoing rather than occasional, and organized rather than amateurish" (1978, p. 212).

The Counselor as Conceptualizer

There is a saying that goes something like, "In order to see the spectrum one must have a prism." The school counselor's function as a conceptualizer or prism of behavior disturbances is perhaps one of the most important and least discussed guidance activities. The counselor is in a unique position to view the spectrum of socio-emotional development from mental health to mental illness, and his/her expertise serves as a prism to focus the concerns of families and school personnel relative to the behaviors of a given child.

In general, the counselor's function in the area of emotional disturbance is to determine the location of the problem, severity of the symptoms,

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and needed intervention services. The counselor, through careful data-gathering which involves observing the child; interviewing the child, parents or teacher; and sampling various learning behaviors through formal or informal testing procedures, develops an hypothesis about the cause and cure of the problem. The counselor might conclude that an adaptive match between the learner's socio-emotional needs and the learning environment is not possible within that school setting and thus identify an appropriate referral to a more optimal environment such as a special class, mental health clinic, or special residential school. On the other hand, the counselor might conclude that additional support services are all that are needed within the school's mainstream to help the child achieve a more satisfactory adjustment to the total school milieu.

One method of conceptualizing the conflict of a student is to view the problem situation in terms of whether it suggests a true developmental crisis or a temporary crisis reaction to a current problem in living. Narrow-band or situational problems usually affect only a small part of the student's life, whereas developmental and wide-band problems spill over to permeate many aspects of the student's functioning. The number of areas of a student's life which are affected by the problems provides a good measure of the severity of the problems. Moreover, the effects of disturbance or conflict tend to be geometric in nature rather than lineal. The number of areas of needed intervention also provides a rough guide to the type of service required (as illustrated in Figure 1). Severely disturbed children have difficulties at school, at home, and in the community. Moderately disturbed children tend to experience problems both at home and at school but do not experience major difficulties within the larger community environment. Mildly disturbed students usually have greatest difficulty in adjusting to the school environment and some difficulty at home. Marginally adjusted students are just that--marginally functioning in each of these environments. Such students are nonetheless at high risk for experiencing difficulties in one or more of these environments if their adaptive skills are not increased. The mentally healthy child generally possesses enough adaptive responses to react to all three environmental demands and stresses in a positive if at times less than optimal fashion.

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Indirect Services

Developmental Group Counseling

Given the increased demand for school counseling services, it is not surprising that group counseling techniques are being increasingly utilized to help school-aged children deal with the normal stresses and conflicts of life in a life-like social milieu. While questions of the relative merits and limitations of group counseling are still being evaluated, group counseling has been shown to be both efficient and effective when common problems among groups of students are identifiable and resolution of those problems can be facilitated by the group process (Muro & Freeman, 1969).

Group counseling techniques are particularly well suited to many of the problems manifested by marginally adjusted and behavioral-disordered students. The potential result of the group experience for these students is a reduction in their feelings of being different and an increase in their available adaptive responses. Unlike one-to-one counseling, group experiences provide a more nearly real-life situation in which to work out conflicts and learn more effective ways of relating to people. The problem of transfer or generalizability of the new social learning is reduced since the skills are acquired in their natural social context. The group provides opportunities for immediate evaluative feedback of the effects of one's behavior as well as vicarious learning opportunities for the more reticent child. Since objectivity is necessary for successful adaptation and accommodation to environmental demands, it is important for these children to learn to get outside of themselves and become more other-centered rather than self-centered. The group process is a useful way of achieving this. The group provides opportunities for children to explore their ideas and actions and at the same time to share and integrate the ideas and acts of others.

A number of factors should be considered in forming counseling groups, such as purposes, group composition, group size, and physical setting (Dimick & Huff, 1974). Generally, school counseling groups can be designed to help children negotiate successfully the various stages of social-emotional growth. A number of models are available in the literature which describe the usual sequences of social, cognitive, and moral development (e.g., Erikson, 1963, 1964; Hewett, 1968; Kolhberg, 1976; Selman, 1976). These models and others can be used to structure group counseling directions and activities.

Children need support as well as systematic learning opportunities to complete the developmental tasks of childhood. Group counseling processes can be utilized to help children who are experiencing difficulty or who are at high risk for experiencing difficulties. The concern about group composition in school settings is really a matter of understanding the expected or desired outcomes of the group counseling process. Generally a balance of problem types tends to make the group easier to manage. If the group consists of only emotionally disturbed children, there will be little opportunity to role model appropriate responses or to increase general social adaptiveness. On the other hand, group members should have enough in common that mutual problem exploration and communication are possible.

A number of authors have suggested that group size should depend upon the age and maturity of the children involved. Younger children might benefit more from interaction with groups of four to six children. Older children might be able to benefit from larger groups of six to eight members. The group size should be determined in part by (1) the opportunities afforded each member to participate or to be inactive as he/she wishes; (2) the ability of the counselor to be aware of and deal effectively with the dynamics of their mutual interactions; and (3) the kinds of behavior problems represented within the group (Dimick & Huff, 1974).

Diversity of opinion also exists with regard to the number of sessions, length of sessions, and duration of a group. Ohlsen (1968) recommended that children's groups meet 40 to 45 minutes, three times per week. Other writers suggest that group counseling is most effective on a one-period-per-week basis during the 18-week semester. Again, these factors depend on the purpose for forming the group. If a counselor is focusing on developmental and/or common life situational crises, then the once-a-week "class" type of structure is appropriate. If a group is working on intense problem-solving techniques for increasing adaptive affective responses, then members may need to meet three times a week.

Stress and Anticipatory Group Counseling

Group counseling within the school would also seem to be an appropriate vehicle for dealing with predictable stressors which pervade even the lives of children and youths. Much has been written lately about stress and stress management in adult life. Very little has been written on prevention and management of stress in children, or on "anticipatory" counseling within a group framework (Klingman, 1978). Stress is the nonspecific response of the body to demands made upon it; it is the common denominator of all adaptive reactions of the body. Individual responses to stress may vary greatly. Events which are labeled "stressors" may also vary greatly with respect to their intensity, duration, predictability, complexity, frequency, and the degree of resultant disorganization.

Significant changes in the child's primary social and emotional support systems as well as significant changes within the child's own psychobiological system tend to be predictors of stress. Counselors who are aware of these stressors can anticipate their occurrence and conduct anticipatory group counseling sessions to lessen their impact on the child. For example, changes in the child's home system such as the prolonged absence of a parent, a different primary caretaker, divorce or separation, change in the health of a parent, change of responsibilities in the family, addition or loss of a sibling, changes in the family income, even family vacations, can be stressful to normal children. Changes in the child's primary socializing system such as loss of a friend, death of a pet, changes in neighborhood, changes in recreational activities, changes in daily schedule, are stressors. Psychobiological stressors include serious personal illness or injury, puberty, development of secondary sex characteristics, and growth (too little or too much). Changes in the school system such as the beginning or end of the school year, change of teacher, school difficulties or failures, troubles with fellow students or teachers, and success in school, are characteristically stressful happenings in the life of a child.

Behaviors which are symptomatic of a stressed child or youth include proximity-seeking, attention-seeking, withdrawal from the environment, hesitancy to explore new environments, delinquency/acting-out, high or low activity rates, poor school performance, sleep disturbances, refusal to eat, and general signs of anxiety such as sweaty hands, shallow breathing, or general agitation and disorganization.

Group counseling can be used to explore common but stressful changes in the child's primary environments, to help identify stability zones at home and at school, and to provide alternative behavioral responses for coping with stress and change. Many new techniques such as relaxation training, decision-making curriculum, and affective education are being used in the schools with emotionally disturbed as well as normal children to increase their resiliency to the changing and increasingly complex demands of living and growing up in a stressed, Type A society.

Suicide prevention through group counseling. Currently, the most tragic index of deviant or nonadaptive behaviors in our schools is the escalating suicide rate. Suicide and attempted suicide are now major health problems for school-aged children. Klagsburn (1976) reports that more young people are dying by their own hand than from cancer and other health ailments combined. Over 4,000 young suicides are recorded yearly. It is estimated that suicide attempts among the school population range from 200,000 to 400,000 yearly. The probable causes of suicide and suicide attempts are varied. Family disorganization, loss of love object, certain personality constellations, and depression appear to be the major precipitators (Lee, 1978). Studies by Miller (1975) reveal that a high percentage of suicide attempts have a history of disorganization and loss. The loss of a parent either through death or divorce is a devastating experience for certain kinds of children who are unable to resolve their sense of parental abandonment and rejection. Any child who suffers the loss of a parent is vulnerable; some children turn their anger inward, an act which according to some researchers may culminate in suicide. The grief over the loss of a loved one, human or nonhuman, may be overwhelming to a child with few coping mechanisms. For very young children, identification with the love object may be so close that suicide is seen as a mechanism for becoming reunited.

Breed (1972) describes five components in the suicidal syndrome: excessive commitment, rigidity, failure, shame, and isolation. Lee observes that:

> the student who is an overachiever, a loner, submits easily to peer pressure, cannot adjust to academic or social failure, has inappropriate aspirations and needs a supportive and overly structured environment appears to have the combination of characteristics for the suicide decision. (1978, p. 201)

Depressive illness, excessive withdrawal and/or anxiety, agitation, apprehension, alienation, and a pervasive sense of hopelessness and helplessness are also characteristic of a potential suicidal state (Lee, 1978). Depressive illness exists in childhood (French & Stewart, 1975), and it is relatively common in later adolescence. Depressive reactions underly many maladaptive behaviors often seen in adolescents such as truancy, delinquency, aggression, excessive or low activity levels, and boredom.

Additional signs and symptoms of potential suicidal gestures which can be observed in the school setting include a "flat-affect" or dull emotional tone to the student's behavior, irritability, inability to concentrate, excessive difficulty with making decisions, and physical signs such as weight loss, headaches, and insomnia.

Counselors either through direct or indirect services can take an active role in suicide prevention and the promotion of more adaptive responses by alerting teachers to the significant behavior constellations of potential suicide, by direct counseling with high risk students, by disseminating information to parents and students relative to mental health practices for dealing with stress, by teaching children and adolescents about mental health, and by responding on an individual basis to a cry for help before it becomes a suicidal act.

Direct Services

It is difficult, at times, to differentiate students with developmental and/or situational problems in social adjustment from students with more serious emotional disturbances. The surface behaviors are often quite similar; it is the underlying dynamics of the behaviors which differ. Emotionally disturbed children are usually characterized by inner tensions, anxiety about their behavior, and difficulties with affect. Most interventions which are suggested for the school setting focus on managing and redirecting surface or situational behaviors, whereas most intensive psychotherapeutic interventions aim at reconstruction of the child's inner psychological and/or biophysical characteristics. In the opinion of this author, appropriate responding contributes to the optimal psychophysiology of a disturbed child and optimal psychophysiological conditions increase the child's capacity for appropriate responding. The emergence of holistic medicine is rendering the chicken/egg question obsolete, and causes and cures of emotional disturbance are characteristically interactive in nature. Psychological, psychosocial and physiological factors interact to produce adaptive or nonadaptive responses to environmental stimuli.

In a study by Morse, Cutler, and Fink (1964), the characteristics of 441 children in programs for the emotionally disturbed were listed as follows:

1. The range of ages was from 5 to 15, with a mean of 9.4 years for the boys and 9.8 years for the girls.
2. Of the group, 83.2% were boys and 16.8% were girls.
3. The teacher rated the majority of children as educationally retarded compared with their chronological-aged expectancy.
4. The I.Q. range was 68 to above 132. The majority of children had I.Q.'s over 100.
5. More than half of the sample were classified as neurotic, with "acting-out" as the dominant conduct problem. Another large group was classified as "immature."

A similar study conducted by the California State Department of Education reported by Kirk (1972) indicated that emotionally handicapped students were significantly different from nonhandicapped students in the following respects: (1) below average school performance and achievement; (2) more referrals to vice principals for disciplinary action; (3) more frequent dropouts; (4) more unexcused absences; (5) more frequent health problems; (6) more often the subject of home calls by child welfare workers, probation officers, and police; (7) more often served by the school counselor and/or referred to local guidance clinics.

Emotionally disturbed children are children who for a variety of reasons are disturbing to themselves and/or their environments. Severe emotional disturbance tends to follow a bimodal curve of incidence rates with peak referrals for service roughly corresponding to ages 3-5 and 13-16 years. The reasons underlying this bimodal condition are varied and probably interactive. Regardless of the specific reason(s), the fact is that the child's behavior is out of synchronization with parental and societal expectations to the degree that a referral is deemed necessary.

Preschool Years (3-5)

In the past, school counselors have had little assigned responsibility for preschool-aged children. The current thrust toward preventive programs in mental health and the requirements of PL 94-142 for preschool services for handicapped are rapidly changing the school counselor's role with this population. It is clear that specific forms of childhood psychosis such as infantile autism and symbiotic psychosis appear in infancy and the preschool period, while it is generally held that schizophrenic disorders do not (Harper, 1978). The psychopathological basis for future character disturbances and psychosis is believed to be rooted in some adaptive failure in one or more phases of development in the first 3-4 years of life. It is hypothesized that in the more severe disturbances, the initial psychophysiological substratum was inadequate which contributes to significant failures in social-emotional development. Treatment or intervention with severely emotionally disturbed preschool children usually involves environmental and physiological restructuring so that the child is more available and accessible to needed social-emotional programming.

The counselor's function becomes one of early detection of severe disturbance, appropriate referral for primary treatment, and consultation with the child's future teachers so that an optimal schooling environment may be arranged. Generally speaking, if significant problems appear this early in a child's life, psychiatric referrals are in order. The less significant disturbances in preschool children can be handled by one or more of the indirect counseling and educational strategies which have been described or by one or more of the direct service techniques which will be described. The key counseling functions for this age group are close monitoring of preschool performance and advocating for services when less than optimal performance is detected.

Elementary and Secondary School Years

The typical problems of emotionally disturbed school-aged children which are laid at the counselor's doorstep can be roughly indexed by age. The more common problems by age are as follows:

1. 6-7 years. Not many children of this age are referred for specific help within the school. If problems are severe and pervasive, psychiatric referral is often sought by parents. Signs of problems are noted by classroom teachers but not generally acted upon beyond conferring with the parents until school adjustment is seen as significantly inadequate.

2. 7-9 years. Most referrals are for children whose behavior is usually characterized as overactive, aggressive, withdrawn, or immature. Poor health, poor school attendance, and poor school performance usually accompany one or more of the above behaviors.

3. 9-12 years. Most referrals are for students who exhibit excessive behaviors such as lying, cheating, fearfulness, school phobia, school failure, various adjustment reactions, high anxiety, tics, presexual exploration, poor peer relationships, and various neurotic behaviors.

4. 12+ years. Students referred usually manifest characterological problems, neurotic compulsive behaviors, performance anxiety, extreme detachment, depression, sleep disturbances, eating disturbances (especially females), suicidal ideation, various drug and alcohol problems, peer rejection, extreme aggression, destructive and/or delinquent behaviors.

A number of intervention techniques will be reviewed which can be used by the counselor for the more predictable social-emotional problems of children and youths such as behavioral change strategies, developmental strategies, relaxation training, life-space interviewing, affective education, parent education, peer counseling, and other supportive therapies such as therapeutic play and re-education. References are provided for the counselor who wishes more detailed and comprehensive descriptions of the various approaches.

Counseling Techniques

Behavioral change. Proponents of behavior modification and behavior management approaches for correcting disturbing behavior view the manifest behavior as the appropriate focus of intervention. All behavior, adaptive and nonadaptive, is a learned response used to operate on the environment. Responses may be understood in the terms of the antecedents in the child or environment, the specific behavior itself, and the consequences of that behavior. Behavior which gains reinforcement tends to be maintained. Behaviorists assume that the same principles which account for the acquisition and maintenance of nonadaptive behavior can be used to teach more productive responses. Operant conditioning in its most simple terms means reinforcing the described behavioral responses in such a way as to strengthen the probability that the desired behavior will be repeated. Various systems of behavior modification may range from extremely sophisticated counting and charting of desirable or undesirable behaviors, arranging consequences, and establishing reinforcement schedules to increase or decrease their likelihood of occurrence; or they may be informal approaches such as "catch the child doing what you want and reward that behavior." Teacher or counselor attention is perhaps the most potentially powerful consequence for behavior of school-age children. The crucial elements of behavioral control include sensible and fair rules or expectancies, appropriate consequences, and planned ignoring whenever possible of low-frequency, deviant behavior (Reinert, 1976). In other words, tell the child what is expected; then reward the desired response and ignore undesirable responses.

Contingency management of behavior is a close companion of behavior modification techniques and is based on the same principles of using positive reinforcement. The primary difference is that contingency management is a contractual agreement between the student and the teacher and/or counselor that each party will perform in such-and-such a manner and the consequence of the behavior will be such-and-such. Usually in contingency contracting low probability behaviors are rewarded with high probability behaviors. Another description for contingency management is "Grandma-Law"--"You may have dessert when you have eaten all your green vegetables."

Eating dessert is a high probability behavior and eating all one's vegetables is a low probability behavior. By pairing the two behaviors, the likelihood of the occurrence of low behaviors is increased. Contingency management is becoming a popular alternative to dealing with children's conflicts as well as structuring adult reactions to conflicts to become more positive. Homme (1970) has written a readable, easy guide for school personnel on the use of contingency management; however this like other techniques of behavior change must be governed by ethical and humane thinking before it is applied.

Behavior change techniques are commonly used with four clusters of behavior problems: acting-out behaviors, withdrawing behaviors, defensive behaviors, and disorganized behaviors. Reinert (1976) offers the soundest rationale for using systematic behavior change techniques by listing the methods which typically fail to bring about positive change in these behavior clusters. It is important that the counselor and/or teacher keep in mind the methods which have low probability of bringing about adaptive responses and/or reducing environmental stresses.

Methods which fail to change acting-out behaviors include physical punishment, ridicule, confrontations, questioning the child as to the reasons for acting-out, comparing the child's behavior with that of classmates or siblings, and eliciting a confession of guilt. Methods which fail to change withdrawing behaviors include forcing the child to become more involved, singling the child out, ignoring, asking the child why he/she is withdrawn, and comparing the child with others. Methods that have failed with defensive children include lecturing, taking away prizes or privileges, threatening punishment, suspending the child, and telling the child you are aware of his/her various strategies (Reinert, 1976, pp. 135-139). Severely disorganized children generally cannot be served in the regular classrooms; and there are no hard and fast rules since each of these children will require a carefully planned, one-to-one type of management.

Behavior management and operant conditioning techniques are applicable to a wide range of behavior from deviant to desirable. The techniques are useful in regular classrooms and special settings both for decreasing disturbing behaviors and increasing adaptive responses (MacMillan, 1973).

Self-control curriculum, relaxation therapy, and biofeedback training. Bower (1970), in writing on prevention of mental illness, observed that "forces which increase or enhance the degree of freedom of man's individual or social behaviors are mentally healthful and those which reduce freedom are unhealthful" (p. 363). The school counselor's role with emotionally handicapped children is also one of increasing or building behavior freedom through teaching self-control. Fagen, Long, and Stevens (1975) define self-control in terms of an individual's flexibility to select among various responses to a given situation. O'Leary and O'Leary (1975) emphasize the student's self-management, which consists of self-determined goals and reinforcement standards, self-recording, self-evaluation and self-reinforcement. Each of these meanings has relevance to the counseling concepts presented in this chapter. The counselor through systematic teaching can increase the extent and flexibility of a student's adaptive repertoire, and the counselor as consultant to teachers and parents can suggest responses to students which encourage increased self-management (Fagen & Long, 1979).

Walton (1979) recently suggested the use of biofeedback training and relaxation therapy with emotionally handicapped children to help them develop self-control over a variety of body functions. Biofeedback training involves systematically feeding back to the individual information relative to body states such as body temperature, heart rate, muscle tension, brain activity, and blood pressure. Some additional training is usually necessary to do biofeedback therapy with students, but the potential for generalizing students' self-control of muscle tension and body temperature to the larger problematic area of impulse control is a provocative thought. Brown (1974) used biofeedback techniques to control muscle tension in a young hyperactive child. Kater and Spires (1975) have suggested that biofeedback training would be helpful in teaching children increased task orientation and attention. Green and Green (1977) showed that 86% of 165 children in grades 1-6 could learn to raise the temperature in their hands with only a few minutes of training.

The two bio- or body states which are most associated with relaxation are levels of muscle tension and external body temperature, particularly in the extremities such as fingers. Children can be taught to reduce their tension levels which, among other things, reduces anxiety. Walton (1979) reported that relaxation tapes could be used with disturbed learners to reduce measured muscle tension. Walton (1979) used a relaxation curriculum based on the work of Fagen, Long, and Stevens (1975) and biofeedback training to reduce the inappropriate behaviors of five emotionally disturbed boys. He found that within 16 weeks inappropriate behaviors were reduced by 50% or more in four of the students and muscle tension was significantly reduced in all five subjects.

Life-space interviewing. The technique of life-space interviewing, generally credited to Redl (1959), is a process which is designed to maximize the here and now of behaviors for therapeutic gain (Newman & Keith, 1963). The orientation of life-space interviewing is effective communication with children. Long and Morse (1966) outlined the two major categories of life-space interviewing: emotional first aid on-the-spot, and clinical exploration of life events.

Emotional first aid on-the-spot is a matter of getting the child pieced back together as quickly as possible so that a given activity can continue. The piecing back together of a child who has become "unglued" because of an unexpected frustration may involve explaining to the child the reasons for a change; providing support to the child as he/she tries to cope with feelings of frustration, anger, anxiety; maintaining communication even at moments when the teacher-child relationship is at risk; consistently applying the rules for expected behaviors; and impartially umpiring the intra- and inter-child conflicts.

Clinical exploration of life events is a process of re-presenting the child's disturbing behavior and relating this behavior to similar events which seem to cause difficulties for that child. Redl (1971) offers five techniques which can be used to exploit therapeutically the situational crisis. These include (1) reality rub-in--making the child aware of what really happened. Emotionally disturbed children have a way of glossing over their real problematic behaviors and should be helped to see their contribution to the problem; (2) symptom entanglement--telling and showing children how they can let go of maladaptive responses and still obtain what they need from the system; (3) massaging numb value areas--awakening the potential adaptive responses within the child; (4) new tool salesmanship--promoting alternative responses to a conflicted situation; and (5) manipulation of the boundaries of the self--supporting the child so that he/she can avoid contagion from the deviant behaviors of others and redirect his/her own behavior. Redl suggests that the approach to use cannot be predicted in advance but is situationally determined by the time available at that moment, the receptivity of the child, and the child's relationship with the adult.

Affective education classes. It is tempting for professionals who are working with emotionally disturbed students to give primary emphasis to techniques of behavioral control, environmental structuring, and redirecting behavioral responses. Affective education is less focused on external control and more on the teaching of decision-making, values, attitudes, and insights which will lead to increased self-control. Various approaches to affective development are currently evident in nonspecial school settings and are generally characterized by a student-centered rather than a teacher-centered curriculum. The tools of affective learning have been underutilized by both regular and special educators.

Special students need to develop a number of expressive techniques for exploring their own feelings as well as examining the effects of their behavior on the feelings of others in the environment. Affective education can facilitate appropriate self-expression and personal effectiveness by increasing the student's understanding of the origin and impact of interpersonal transactions. Various authors in education and psychology have described affective approaches to enhancing the child's awareness of self, increased social awareness, parallel valuing, decision-making, and adaptive responding. Among the best known are Simons and O'Rourke's (1977) value clarification approach, Glasser's (1965, 1969) reality therapy and classroom meetings, Chase's (1975) activities for the left side of the report card, Brown's (1971) confluent education, and various mini-courses offered in school settings which are designed to increase available expressive techniques such as art, drama, and poetry (Eyde, 1979). Various instructional materials also can be used to increase the child's social-emotional understanding and encourage alternative responses to environmental problems.

Leisure education and therapeutic play. For a variety of reasons, emotionally disturbed children and youths have failed to acquire many basic leisure-time skills which would enable them to participate in a wider range of recreational activities. In general, deficits in leisure skills impede successful integration into normalized school and community activities. The resulting social isolation further exacerbates existing problems in school and community adjustment. The cycle of isolation will continue until prescriptive leisure education is routinely made available to every learner with special needs.

An examination of PL 94-142 indicates that leisure education is currently authorized in those cases when it is necessary to assist the child's optimal utilization of special education services. The nature of utilization and its relationship to the total prescriptive IEP package is still to be argued. However, counseling and skill-building activities which would maximize the disturbed learner's benefits from leisure time and recreation opportunities would appear to be a worthy goal of a school counselor's energies. Leisure education is an appropriate alternative curriculum for emotionally disturbed learners which can promote positive socialization, increased development of leisure interests, and enhanced sense of self in a reality-based social context.

Therapeutic play as opposed to play therapy is a related but distinct intervention mode with emotionally disturbed children (Reinert, 1976, p. 70). It involves the structuring of play activities so that maximum therapeutic benefits can be achieved. Many conflicted children are developmentally delayed in their play skills because of their disturbed relationship with their environment. Playground activities, appropriate use of play objects, and group games that require cooperation and social awareness are often beyond the child's current functioning. Consequently, individual play skills and parallel play skills may have to be taught before the more complex skills of social play can be acquired. Counseling activities which focus on play skill development are easy to implement in the school setting and, theoretically at least, should provide a counseling vehicle for social emotional development.

Peer counseling. Systematic use of peer counseling is a fairly recent innovation in school counseling. The benefits of peer counseling include an increase in available manpower (Scott & Warner, 1974) to serve the less disturbed student in the school setting, and the generally positive effect of trained peer counselors on the school atmosphere as a whole (Fink, et al., 1978). Fink, et al., noted that as more students are trained and model supportive interpersonal skills in their relationship with peers, a school-wide network of sensitive and empathic students may be created.

In order for peer counseling to be successful the supervisor needs to structure the relationships so that an appropriate match is achieved between the client's needs and the peer counselor's skills. Specific training is probably necessary for peer counselors who might work with more complex counseling problems; however, many emotionally disturbed learners could benefit from simple proximity to a successful age-mate model. Peer counselors can be used as age-appropriate assistants in solving personal problems and teaching age-appropriate social skills. Peers can often function as counseling bridges to the adult world for detached students and ultimately, over a period of time, serve as agents of change. However, the results of the Fink, et al., study suggest that careful planning must precede decisions regarding the utilization of peer counselors and the specific functions assigned to them. These authors suggest the following guidelines for using peer counseling:

1. Emphasize the informal network of trained peer counselors.
2. In the training phase, place great emphasis on counselor's initiation of the helping process and analysis of existing friendships.
3. Select a diverse group of students for training programs that will make peer counselors available throughout the entire sociological strata of the school.
4. Publicize the names of trained peer counselors, thus encouraging clients to initiate informal contact.
5. Emphasize training large numbers of peer counselors in basic skills rather than training a selected group in higher-level skills (1978, p. 82).

Parent education. Most of the current professional literature on working with parents of handicapped children focuses on using parent groups to help parents (1) increase their understanding of the handicapped condition, (2) increase their acceptance of the handicapped child, and (3) increase their skills for helping the handicapped child. Leigh (1975) remarked that parent counseling may, in the long run, be more beneficial to the child than direct therapy. Very little help exists specifically for helping parents of emotionally disturbed learners beyond the usual courses in behavior management skills. Parent counseling must be a two-way process of helping parents define and understand the child's problem, recognize the contributions of the home environment where appropriate, and develop new skills for structuring positive interactions with their child.

Anger, guilt, overprotection, and lack of confidence are common emotional reactions among these parents. Parents often feel helpless and frustrated by the child's special problem. Sometimes anger results in hostility toward the child or toward the counselor, teacher, or other school personnel. Obviously, this will interfere with cooperative planning between the home and school. In addition to defusing some of the inherent hostility, the parent counseling process should provide a more complete informational base so that parents may more realistically examine their reactions.

With this population of special children, parents often blame themselves or their spouses for the child's invisible illness. Parents tend to review past transgressions and mishandling of the child--which only increases their sense of guilt. Counseling can be cathartic for some parents, or it can help to substitute current positive interactions with the child for old guilt.

Overprotection is a common reaction of parents, stemming in part from guilt and in part from hostility. Some parents may need to prolong the child's problem so that they don't have to face more intense personal problems of their own or in their relationships with others. Direct counseling of parents provides a safe setting where personal conflicts can be explored and perhaps modified.

Parents of children in conflict often need direct counseling in order really to help their children, and a variety of professional options should be made available to them. As Huber (1979) concluded,

> The future of handicapped children will depend on the dynamics of their home situation. Not all activities should focus on the parent, but helping parents work through their adjustment problems also helps their handicapped children. (p. 369)

Human Issues

Techniques of Effective Individual Counseling

1. Getting in touch. To be effective in individual counseling with an emotionally disturbed child, the initial contact should be with the child and not, as is often the case, with the problem. The first step is to get in touch with the student. For the initial moment, ignore the particular referring problem(s) and concentrate on communicating with the individual. Communication that is meaningful between a caring adult and a conflicted child is often therapeutic in itself.

2. Developing a relationship. After the initial contact, the counselor needs to develop a relationship or rapport with the child. Once some form of rapport is established, then the problem can be mutually explored.

3. Getting to the problem. Problems and/or conflicts must be delineated, ventilated, and clarified before alternatives for resolving them can be generated. During the stages of problem clarification, the counselor should be formulating some idea of the resources which will be needed to resolve the conflict as well as fitting the necessary steps into some time frame. At this point in the counseling process, an initial judgment is made as to the comprehensiveness of the proposed intervention (Will bandages suffice, will stitches be necessary, or is social-emotional surgery required?). Also at this point in conflict delineation, the counselor should give thought to matching the problem to possible solutions and to whether the counselor has the time and the intervention skills required to resolve the conflict. If the counselor feels that the particular problem is beyond his/her time and resources, at this point he/she

can elicit help from other school personnel or community mental health agencies.

4. Implementing the strategy. After the problem delineation, ventilation, and clarification, the counselor should implement the chosen strategy to be used by the counselor and/or arrange for supportive services.

5. Following up and following along. Even after the implementation phase, the counselor must remain involved in a follow-up capacity. Follow-up means more than just occasional monitoring of progress; it means anticipating spin-off problems and being prepared to deal with them. Follow-up means staying in touch with the child as well as communicating with others in the treatment environment to ensure that progress is continuing.

Individual counseling, when it is working, is like a magic ballet involving the participants in a *pas de deux* of responding, relating, valuing, organizing, and integrating their mutual acts, intentions, and reactions. As noted in earlier sections of this chapter, individual counseling with emotionally disturbed learners includes important liaison work with the family and/or other community agencies.

Personal Qualities

In the role of therapeutic change agent of disturbing behaviors, the personal qualities of a successful school counselor take on added importance. Dimick and Huff (1974) have identified a number of characteristics which appear to contribute to positive outcomes in the counseling process. Spontaneity, flexibility, concentration, openness, emotional stability, a belief in people, and commitment to their ability to change appear to be key variables in facilitating growth and change (Dimick & Huff, 1976, pp. 109-113).

Personal Commitments

Furthermore, successful counselors of emotionally disturbed learners must possess those qualities which enable them to serve as mediators and advocates for each of the students in their care. As Bower (1970) observed, in order to prevent emotional disorders in childhood, each child needs "a mediating adult." The mediating adult is able to "lower and connect affective bridges with children over which all kinds of important cognitive-affective traffic can pass" (p. 559). The emotional growth of any child depends upon positive interaction with the environment. Without direct intervention the emotionally disturbed child will characteristically have limited, selective, and overwhelmingly negative interactions with his/her environment. The school counselor thus lowers the bridge, functioning as a mediator of inner experiences and environmental transactions, mediating or remediating between the socio-emotional needs of the child and the ways in which the environment can be structured and restructured to facilitate growth of the child.

Jourard (1968) defined the effective counselor as a "responsible anarchist" providing a loyal opposition to demands that all children must exhibit modal behaviors that fit the system. The counselor must advocate for support services which will facilitate the child's adaptation to various environmental demands and enable the child to realize his/her optimal levels of cognitive and affective development. Hobbs (1964) has advocated that the most effective way to make substantial changes in the mental health of future generations is to concentrate on the children of today. The school counselor as a member of the helping professions must similarily advocate for programs to develop socio-emotional strengths in all handicapped learners if mental health is to be equally accessible to all of tomorrow's adults.

Conclusions and Recommendations

Counseling Emotionally Disturbed: Past and Present

The responsibilities of elementary and secondary school counselors have expanded rapidly in the last 25 years. Counselors have become both generalists in human growth and development and specialists in "human reclamation." The parameters of counseling functions are increasingly transdisciplinary and involve coordination of counseling activities among varied professional and paraprofessional groups. In addition to the many indirect counseling services relating to mental health and mental illness, the school counselor provides direct remediation of deviant and/or delayed social-emotional development for divergent groups of behavioral-disordered students. Several current counseling approaches have been described which appear to have potential for re-education and remediation of disturbed learners, including group counseling, anticipatory counseling, developmental counseling, and individual counseling. However, in addition to these various counseling techniques, a systematic guidance curriculum is needed if counselors are going to serve the mental needs of all students including the emotionally handicapped.

The goals of a counselor's mental health curriculum guide would be personal development and improvement of interpersonal communication of all students through direct though not necessarily formal teaching by counselors (Herr, 1979). The content of a guidance curriculum should be knowledge relating to self-understanding, decision-making, planning for positive mental health outcomes, stress prevention and stress management, and knowledge of the self in relationship to the large society and to the world of work. The specific instructional characteristics of a guidance curriculum would vary according to the needs and placement of individual students. It is within such a mental health guidance curriculum that issues relative to alternative curriculum for special groups, e.g., affective curriculum, adapted vocational preparation, career education, and total life planning, could be jointly explored by teachers--regular and special. In order for a functional guidance curriculum to be realized, counseling education itself needs to reorganize its prioritization of training competencies so that human resource development and human reclamation rather than human management are the focus. Evaluative research of expected curriculum and counseling outcomes needs also to be a prime concern in counselor education.

Counseling Emotionally Disturbed: The Future

Mental health needs are pervasive within the school setting. Consequently, counseling activities must become proactive and preventive rather than reactive and crisis-oriented (Rimel, 1979). The counselor must articulate the needs of the students within the school in terms of future community adjustment and, conversely, translate community survival skills into instructional activities. Outreach activities, increased liaison among agencies, community education, increased parent education, and planning for the natural life-cycles of handicapped adults are also new but significant counseling functions of the future. However, the development and implementation of career education/work therapy programs for emotionally handicapped learners is the single most pressing concern for the future. Without a well-conceived career education program for this population of special learners, all of our other efforts will fall far short of our goal, which must be equal access to a satisfying quality of life for all children.

Summary

This chapter focused on the special counseling needs of emotionally handicapped learners and the school counselor's role as a mental health consultant, mental health collaborator of individual learning programs (IEPs), and mental health conceptualizer of emotional and/or behavioral problems in the school setting. Group counseling techniques for developmental counseling and anticipatory counseling for stress and suicide were examined. Individual counseling activities with the emotionally disturbed were discussed in terms of current approaches under the headings of typical presenting problems, behavior management, life-space interviewing, affective education, self-control, relaxation therapy and biofeedback training, leisure education and therapeutic play, peer counseling, and parent counseling. Personal qualities which enhance the counseling process were identified, as well as the important functions of the counselor as a mediator of special learning needs and an advocate for special learning services. Lastly, it was proposed that a specific guidance curriculum be developed to meet the mental health needs of all school-age students and a career education/work therapy curriculum be developed for the special needs of the emotionally handicapped student.

REFERENCES

ACES-ASCA Joint Committee on the Elementary School Counselor. *Report of the ACES, ASCA committee on the elementary school counselor*. Washington, D.C., 1966. (Mimeograph)

Amidon, E. J., & Simon, A. Teacher-pupil interaction. *Review of Educational Research*, 1965, *25*, 130-140.

Bower, E. *Early identification of emotional handicapped children in school*. Springfield, IL: Charles C. Thomas, 1960.

Bower, E. Primary prevention of mental and emotional disorders: A conceptual framework and action possibilities. In L. Faas (Ed.), *The emotionally disturbed child: A book of readings*. Springfield, IL: Charles C. Thomas, 1970, 355-379.

Bower, E. K.I.S.S. and kids: A mandate for prevention. *American Journal of Orthopsychiatry*, 1972, *42*, 556-565.

Breed, W. Five components of a basic suicide syndrome. *Life Threatening Behavior*, 1972, *2*, 3-17.

Brophy, J. E., & Good, T. L. Teacher's communication of differential expectations for children's classroom performance. *Journal of Educational Psychology*, 1970, *61*, 365-374.

Brown, B. *New mind, new body*. New York: Harper & Row, 1974.

Brown, G. I. *Human teaching for human learning: An introduction to confluent education*. New York: Viking Press, 1971.

Caplan, G. *The theory and practice of mental health consultation*. New York: Basic Books, 1970.

Chase, L. *The other side of the report card: A how-to-do-it program for affective education*. Santa Monica, CA: Goodyear Inc., 1975.

Cormany, R. B. Returning special education students to regular classes. *Personnel and Guidance Journal*, 1970, *48*, 641-646.

Dimick, K. M., & Huff, V. E. *Child counseling*. Dubuque: W. C. Brown Co., 1974.

Erikson, E. *Childhood and society*. New York: Norton, 1963.

Erikson, E. *Insight and responsibility*. New York: Norton, 1964.

Eyde, D. R. *What's the name for what I feel? Developing instructional options for severely and moderately emotionally disturbed adolescents.* Paper presented at the International Convention of the Council for Exceptional Children, Dallas, Texas, April, 1979.

Fagen, S. A., & Long, N. J. A psycho-educational curriculum approach to teaching self-control. *Behavioral Disorders*, 1979, *4*, 68-82.

Fagen, S. A., Long, N. J., & Stevens, D. J. *Teaching children self-control: Preventing emotional and learning problems in the elementary school.* Columbus, OH: Charles Merrill, 1975.

Fink, A. H., Grandjean, P., Martin, M. G., & Bertolini, B. G. Service delivery and high school peer counseling systems. *Personnel and Guidance Journal*, 1978, *57*, 80-83.

Flanders, N. A. *Analyzing teacher behavior*. Reading, MA: Addison-Wesley, 1970.

French, A., & Stewart, M. Family dynamics, childhood depression, and attempted suicide in a 7 year-old boy: A case study. *Suicide*, 1975, *5*, 29-37.

Ginott, H. G. *Teacher and child*. New York: MacMillan, 1972.

Glasser, W. *Reality therapy*. New York: Harper & Row, 1965.

Glasser, W. *Schools without failure*. New York: Harper & Row, 1969.

Glidewell, J. C., & Swallow, C. S. *The prevalence of maladjustment in elementary schools: A report on the Joint Commission of the Mental Health of Children*. Chicago: University of Chicago Press, 1969.

Gordon, T. *Teacher effectiveness training*. New York: Wyden, 1974.

Graubard, P. S. Children with behavioral disabilities. In L. Dunn (Ed.), *Exceptional children in the schools*. New York: Holt, Rinehart & Winston, Inc., 1973.

Green, E. E., & Green, A. M. *Beyond biofeedback*. New York: Delacarte Press, 1977.

Hansen, C. E. The special education counselor: A new role. *Exceptional Children*, 1971, *38*, 69-70.

Harper, R. T. Psychopathology in the pre-school child and its assessment. In N. B. Enzer & K. W. Goin (Eds.), *Social and emotional development: The pre-schooler*. New York: Walker & Co., 1978.

Herr, E. L. *Guidance and counseling in the schools: Perspectives on the past, present and future*. Washington, D.C.: American Personnel and Guidance Association, 1979.

Hewett, F. *The emotionally disturbed child in the classroom.* Boston: Allyn & Bacon, 1968.

Hobbs, N. Mental health's third population. *American Journal of Orthopsychiatry*, 1964, *34*, 822-833.

Homme, L. *How to use contingency contracting in the classroom.* Champaign, IL: Research Press, 1970.

Huber, C. H. Parents of the handicapped child: Facilitating acceptance through group counseling. *Personnel and Guidance Journal*, 1979, *57*, 367-369.

Hunt, J. T. Guidance and exceptional children. *Education*, 1960, *80*, 344-348.

Hyde, E. M. School psychological referrals in an inner city school. *Psychology in the Schools*, 1975, *12*, 412-420.

Jourard, S. M. *Disclosing man to himself*. Princeton: Van Nostrand Co., Inc., 1968.

Kahnweiler, W. M. The school counselor as consultant: A historical review. *Personnel and Guidance Journal*, 1979, *57*, 374-378.

Karel, F. (Ed.). *New approaches to child care services focus attention on the nation's schools*. Princeton, NY: Robert Wood Johnson Foundation, *Special Report, No. 1*, 1979.

Kater, D., & Spires, J. Biofeedback: The beat goes on. *School Counselor*, 1975, *23*, 16-20.

Kelly, T. J., Bullock, L. M., & Dykes, M. K. Behavioral disorders: Teachers' perceptions. *Exceptional Children*, 1977, *43*, 316-318.

Kicklighter, R. H. School psychology in the U.S.: A quantitative study. *Journal of School Psychology*, 1976, *14*, 151-156.

Kirk, S. A. *Educational exceptional children*. Boston: Houghton Mifflin Co., 1972.

Klagsburn, F. *Too young to die*. Boston: Houghton Mifflin Co., 1976.

Klingman, A. Children in stress: Anticipatory guidance in the framework of the educational system. *Personnel and Guidance Journal*, 1978, *57*, 22-26.

Kohlberg, L. Moral stages and moralization. In T. Lickons, et al., *Moral development and behavior*. New York: Holt, Rinehart & Winston, 1976.

Lee, E. S. Suicide and youth. *Personnel and Guidance Journal*, 1978, *57*, 200-220.

Leigh, J. What we know about counseling the disabled and their parents: A review of the literature. In L. Buscaglia (Ed.), The disabled and their parents: A counseling challenge. Thorofare, NJ: Charles B. Slack, 1975.

Long, N. J., & Morse, W. C. Special classes for children with social and emotional problems in the public schools. In W. W. Wattenberg (Ed.), Social deviancy among youth. Chicago: National Society for the Study of Education, 1966.

MacMillan, D. Behavior modification in education. New York: The MacMillan Co., 1973.

Marmor, J., & Pumpian-Mindlin, E. Toward an integrative conception of mental disorder. Journal of Nervous Mental Disorders, 1950, 3, 19-29.

Meyers, J., Parsons, R. D., & Martin, R. Mental health consultation in the schools. San Francisco: Jossey-Bass Publishers, 1979.

Miller, J. P. Suicide and adolescence. Journal of Youth and Adolescence, 1975, 10, 11-12.

Morse, W. C., Cutler, R. L., & Fink, A. H. Public school classes for the emotionally handicapped: A research analysis. Arlington, VA: The Council for Exceptional Children, 1964.

Muro, J. J., & Freeman, S. L. Readings in group counseling. Scranton, PA: International Textbook Co., 1969.

Newman, R. G., & Keith, M. The school centered life space interview. School Research Program, P.H.S. Project OM-525. Washington, D.C.: Washington School of Psychiatry, 1963.

Office of Education, U.S. Department of Health, Education, and Welfare. Education of handicapped children and incentive grants program. Federal Register, part IV, December 30, 1976.

Ohlsen, M. M. Counseling children in groups. The School Counselor, 1968 15, 343-349.

O'Leary, S. G., & O'Leary, K. D. Behavior modification in the school. In H. Leitenberg (Ed.), Handbook of behavior modification and behavior therapy. Englewood Cliffs, NJ: Prentice-Hall, 1976.

Patterson, C. H. Rehabilitation counseling collected papers. Champaign, IL: Stripes Publishing Co., 1969.

Redl, F. The concept of the life space interview. American Journal of Orthopsychiatry, 1959, 29, 1-18.

Redl, F. The concept of the life space interview. In N. Long, W. Morse, & R. Newman (Eds.), Conflict in the classroom. Belmont, CA: Wadsworth Publishing, 1971.

Reinert, H. R. Children in conflict. St. Louis: C. V. Mosley Co., 1976.

Reinert, H. R. The emotionally disturbed. In B. R. Gearheart (Ed.), Education of the exceptional child. San Francisco: Intext Educational Publisher, 1972.

Rimel, E. G. Is it feasible to offer guidance and counseling programs of services as a preventive package rather than crisis orientation? The Delta Kappa Gamma Bulletin, 1979, 45, 62-63.

Schmuck, R. A., & Schmuck, P. A. Humanistic psychology of education: Making the school everybody's house. Palo Alto, CA: National Press Books, 1974.

Scott, S. H., & Warner, P. W. Peer counseling. Personnel and Guidance Journal, 1974, 53, 228-231.

Selman, R. Social-cognitive understanding: A guide to education and clinical practice. In T. Lickons, et al., Moral development and behavior. New York: Holt, Rinehart, & Winston, 1976.

Simon, S. B., & O'Rourke, R. D. Developing values with exceptional children. Englewood Cliffs, NJ: Prentice-Hall, 1977.

Spaulding, R. L. An introduction to the use of Coping Analysis Schedule for Educational Settings (CASES). Durham, NC: Educational Improvement Program, Duke University, 1967.

Sproles, H. A., Panther, E. F., & Lanier, J. E. P.L. 94-142 and its impact on the counselor's role. Personnel and Guidance Journal, 1978, 57, 210-213.

Turnbull, H. R. The past and future impact of court decisions in special education. Phi Delta Kappan, 1978, 59, 523-526.

Walton, W. T. Education and treatment of emotionally handicapped children. Provo, UT: Brigham Young University Press, 1979.

Wyne, M. D., & Skjei, P. The counselor and exceptional pupils: A critical review. Personnel and Guidance Journal, 1970, 48, 828-835.

4 COUNSELING THE HEARING-IMPAIRED CHILD IN A MAINSTREAMED SETTING

McCay Vernon and Paula Ottinger

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COUNSELING THE HEARING-IMPAIRED CHILD IN A MAINSTREAMED SETTING

McCay Vernon and Paula Ottinger

Due to a variety of factors, primary among them Public Law 94-142 (the Education of All Handicapped Children Act), public schools are experiencing increasing enrollments of children with a variety of abilities and disabilities which require specialized services and programs. This paper will address various factors relevant to hearing-impaired children who are "mainstreamed" into a public school, and to those professionals charged with meeting these children's needs. These factors have been organized as they relate to the child, the mainstreamed setting, and the counselor, with a final section on available resources.

The Hearing-Impaired Child

A number of facets of hearing loss has significant influence on the hearing-impaired child and his/her functioning and needs. A brief introduction to these is presented here, with suggested readings provided for more in-depth exploration of these topics.

Hearing Characteristics

The first need of any professional serving hearing-impaired individuals is to have a basic understanding of hearing loss and its ramifications.

Levels of hearing loss may be diagnosed by an audiologist and plotted on a graph, reproduced in Figure 1, called an audiogram. The vertical axis on this graph records intensity or volume, measured in decibels (dB). The "threshold" (level at which sound can be detected) for normal hearing is at "0" (zero) decibels, with normal conversation occurring at 50-60 dB. The horizontal axis represents frequency or pitch--how high or low a tone is--measured in Hertz (Hz) or cycles per second (cps).

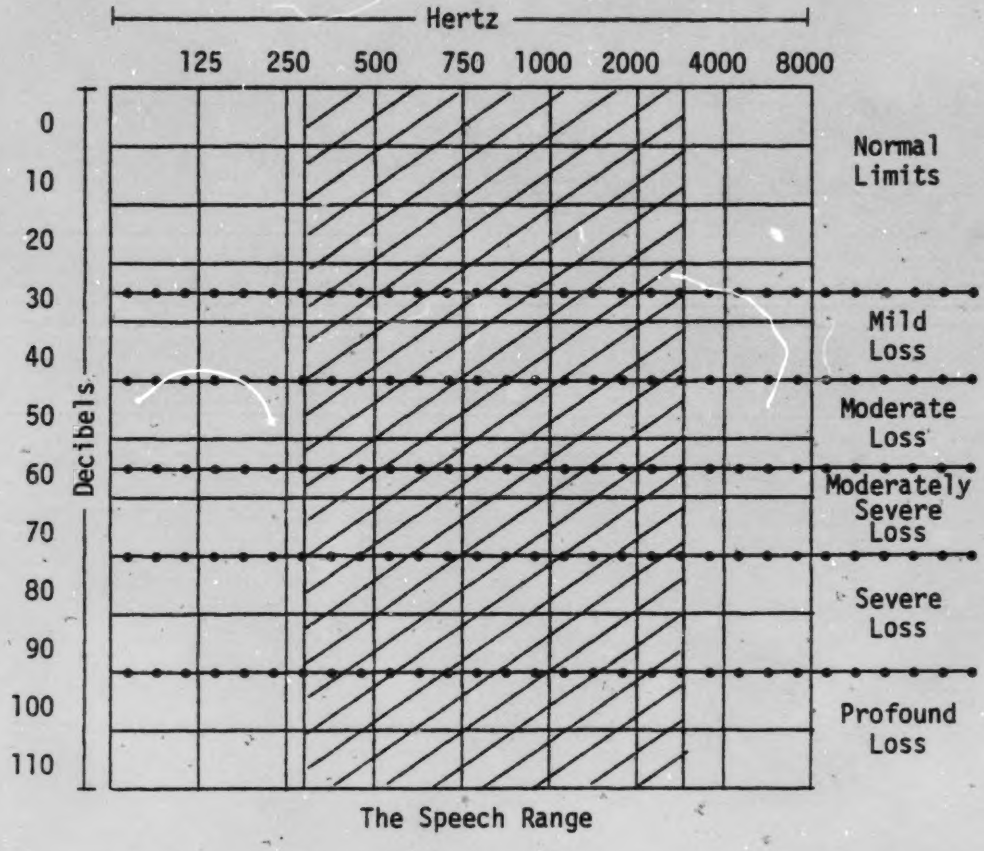

Figure 1. Audiogram

The increasing numbers moving from left to right across the audiogram correspond to pitches which would gradually rise from very low to quite high. The area between approximately 300 Hz and 3000 Hz is where the majority of human speech sounds occur, and is known as "the speech range." The child's hearing ability within the speech range is of special interest because it is so crucial in interpersonal communication and the development of language.

A complete audiological evaluation will include a variety of tests, not only for sound awareness, but also for ability to discriminate (i.e., to understand, or differentiate) speech sounds. These are vital because many types of hearing loss cause not only a loss in volume but distortion of sounds as well. Thus it is possible that a hearing-impaired child may be aware of sound occurring, aware for example that someone is speaking, but be unable to discriminate what is being said, unable to decipher meaning from those sounds.

Obviously, a wide variety of types and degrees of hearing loss can and does occur. The varying categories of hearing loss have been illustrated on the audiogram in Figure 1.

Children whose hearing impairment falls in the categories of mild loss through moderately severe loss are generally referred to as "hard of hearing," and those in the severe to profound categories as "deaf." Generally speaking, hard-of-hearing children (as would be expected) will have more complete language development and more ease with oral communication (i.e., speaking and understanding others' speech) than the deaf, with these skills becoming increasingly impaired in children for whom the hearing loss is more severe. Deaf children typically will need to depend on visual input (for example, the language of signs) more than on auditory channels in order to achieve effective communication and to foster language development. (These topics are presented in greater detail below.) Those working with hearing-impaired children, however, need to recognize that individual abilities will vary widely, even among children who have losses within the same category. Hearing-impaired children are as different from one another as are nonimpaired children. It is not unusual to find a hard-of-hearing child who, due to discrimination or other problems, seems to have difficulty in speech and language beyond that which would be predicted from audiological test reports. Less common, though still encountered, is the deaf child who has developed surprising facility in these areas of communication.

Intelligence

The intelligence of deaf persons has been studied extensively since the early 1900's. A review of approximately 50 independently conducted investigations supports the contention that the deaf and hard-of hearing population has essentially the same distribution of intelligence as the general population (Vernon, 1968). There is no causal relationship between hearing loss and IQ. The lay public's occasional association of deafness with "dumbness" (stupidity) probably rests upon the false assumption that lack of speech and/or difficulties with written language, as often seen in the deaf population, are reflections of lack of intelligence, rather than simply of lack of exposure to English through hearing (Vernon, 1969). It is crucial that professionals serving deaf children realize that language skill does not equate with intelligence; impaired linguistic functioning in the deaf child is a consequence of impaired hearing, not of impaired intellectual capacity.

Communication Characteristics

The major handicap imposed by the disability of deafness is that of impaired communication. A number of aspects of communication must be considered, including language, speech, speechreading, reading and writing, and manual communication (fingerspelling and the language of signs).

Language. For most children the normal process of developing receptive and expressive language capabilities is well under way by the age of two to three years. Although vocabulary and, to some extent, syntactic sophistication will continue to be refined later, the child will have mastered the basic elements of his/her language by the age of four (Moores, 1978).

This almost miraculous realization of human language capacity is made possible, of course, by the virtually continuous give and take of spoken language (reception and expression) that begins the moment the child is born. This process is, quite obviously, inhibited by the inability to hear. While deafness *per se* does not destroy the native language potential, it does interfere with the process by which language competence normally develops. As a result, the deaf child's level of language development will typically be years behind that of hearing peers. The average deaf child enters school without the solid English language base which serves as the foundation for reading and writing for his/her normally hearing counterpart. Some deaf children may develop skills near those expected in nondisabled children, but they are a rare exception.

Reading and writing. Persons unfamiliar with deafness and its effects on language development are frequently surprised--and dismayed--when they see samples of the written language of deaf children or become aware of their achievement scores in reading. Numerous studies involving deaf students and adults have found the average deaf individual to be grossly undereducated in comparison with hearing peers (Boatner, 1965; DiFrancesca, 1972; McClure, 1966; Trybus & Karchner, 1977). While this is partially an indication of the extent of the language handicap (and subsequently the impediment to education) which deafness may impose, it is also an indictment of the traditional educational systems and approaches which have failed to develop the intellectual capacity of deaf students (Vernon, 1969).

Speech. Most of us studied a foreign language in high school or college and recall how difficult it was to learn to speak it. This difficulty occurred despite the fact that we were able to hear the foreign language sounds we were to imitate, as well as to monitor our own attempts to articulate them and to correct these approximations. Consider how well we would manage the task of learning to speak French or Russian if we had never heard it spoken, and had no other spoken language sounds to use as reference points for comparison. Imagine, then, how difficult a task confronts the hearing-impaired child attempting to produce speech sounds which are perceived in a distorted fashion, or not at all, without having the capability for auditory self-monitoring.

As a consequence of these difficulties, it is rare for persons who are prelingually deaf to develop intelligible speech (Vernon, 1969). Even those whose speech is understandable to persons familiar with it will in

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all probability retain certain voice and speech patterns which seem "unnatural" or strange--monotone, unusual pitch or speech rhythm patterns, or inability to produce certain speech sounds. This reality cannot be ignored or glossed over by professionals guiding the child and his/her parents.

Speechreading. Myths about speechreading (formerly commonly called lipreading) are rampant in the general public, fostered by movies and television programs depicting such ludicrous situations as a spy speechreading a conversation occurring across a dark street.

In reality, speechreading is an almost awesomely difficult guessing game, as illustrated by the research in speechreading done by the John Tracy Clinic (Lowell, 1957-1958, 1959). These studies compared the speechreading skill of nondeaf college sophomores, who had never studied speechreading, to the skill of deaf children and adults to whom it had been taught most of their lives. Their findings indicated that the nondeaf subjects were more successful at this task. This was due to the fact that they had a solid language base (syntax and vocabulary) which enabled them to "fill in" the words which they could not speechread. Approximately 40% to 60% of English speech sounds look the same on the lips as some other speech sound. Therefore, a person lacking a substantial language base, who is thus less able to fill in the gaps which occur in speechreading, often understands very little. In actuality, studies have indicated that the most skilled speechreaders, in a one-to-one situation, understand only about 26% of what is said (Lowell, 1957-1958, 1959). Many bright, otherwise capable deaf children grasp less than 5%. Thus it is clear that, for the prelingually deaf child who has an incomplete language base, use of speechreading as a major modality for instruction is an unrealistic educational task (Vernon, 1969).

Hearing aids. The use and benefits of hearing aids, again, are areas of frequent misunderstanding for the lay public, who frequently believe that wearing an aid will restore normal hearing. Technological progress in recent years has made hearing aids more comfortable and more effective. However, hearing aids are not comparable to eyeglasses for those with visual acuity problems; using an aid is not a panacea which eliminates all of the problems of hearing loss. A complete audiological evaluation will include exploring the possibility of fitting an aid as part of the total rehabilitation program. However, many patients with hearing loss either do not need or cannot use a hearing aid (Martin, 1975). This is the result of a complex interaction of factors in the patient, the type of loss, and the capabilities of available aids. Some persons may realize tremendous benefits from using an aid for environmental awareness and for comprehension of speech. Others may benefit little from an aid, finding only that it serves more to increase the volume of their distorted auditory perceptions, making them even more distracting, than to improve these perceptions in a meaningful way. In addition, there is some philosophical disagreement within the ranks of professional audiologists on the issue of when (at what age), how, and even, in some cases, whether to fit aids on children.

Fingerspelling and the language of signs. Fingerspelling is a system which allows the user to spell out words through a series of discreet positions of the hand, one to represent each letter of the alphabet. The language of signs is a language in which shapes and movements of the hands replace the spoken elements of language used by the hearing population. More than simply gestures, signs are symbols which represent concepts, and they are organized in a linguistic way, comparable to the way in which the movement of the vocal mechanisms allows us to communicate, in spoken form, the words or concepts of English (A Look at American Sign Language, undated). Major advantages of these two types of "manual communication" are that they allow hearing-impaired persons to communicate clearly, efficiently, and without the frustration and ambiguity inherent for them in oral forms of communication (Vernon, 1969).

Total communication. Very briefly, total communication is a burgeoning philosophy within the field of deaf education which supports the use, in combination, of both oral and manual modes (all of those channels listed above). Advocates of total communication believe that this total approach to communicating with the deaf child is the one which provides the greatest number of options, and therefore is apt to present more complete communicative and linguistic input. Since the aural/oral channels through which language competence develops for the normally hearing child are interfered with by deafness, total communication attempts to allow the child's native language potential to be realized through a system in which oral and manual communication complement one another. Early detection of hearing loss and use of total communication represent an optimal opportunity for clear and effective reception and expression in all available channels during the crucial preschool period, the normal language-learning years (Vernon & Koh, 1971). Growth of total communication is receiving increasing support from involved and militant deaf adults (Jacobs, 1974), as well as from numerous studies showing academic achievement among deaf children of deaf parents, who have communication via sign language from birth, to be superior to that of deaf children of hearing parents, who typically have only limited early communication through the oral channels (Meadow, 1968; Stuckless & Birch, 1966; Vernon & Koh, 1970).

The Parents of the Deaf Child

One of the most frequently cited advantages of mainstreaming is that local placement of the child (as opposed to residential) increases the potential for meaningful involvement between the child's home and school. In order for this potential to be realized, professional staff in a mainstreamed setting need to have a basic understanding of the psychodynamics surrounding diagnosis of a child's deafness and the family's coping patterns.

Pregnancy is normally a time of mixed emotions for both of the parents, feelings that typically are even more intense for the mother. Excitement, closeness, and hopefulness are countered by discomfort and some degree of fear and resentment of the impending responsibilities and demands. In unplanned or unwanted pregnancies, one spouse may feel hostile toward or blame the other for the carelessness which led to the conception. Such ambivalent feelings are normal and common, even when the pregnancy is desired. However, these feelings have tremendous implications relative to the feelings of guilt and denial which occur if the child is later diagnosed to be disabled in some way (Vernon, 1973).

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The actual diagnosis of deafness often does not occur until the age of two or three years due to a variety of contributing factors. Few infants have total hearing losses and may respond to loud noises, masking their inability to understand speech sounds. Parents may unconsciously deny their suspicions that something is wrong, explaining their child's lack of responsiveness by saying the child is "just being stubborn" or some other similar excuse. In addition, doctors often foster the delay in diagnosis by regarding the parents' concerns as common manifestations of normal parental anxieties. Parents' expressions of concern that something is wrong may be met with such comments as, "Don't worry--he'll grow out of it," or, "You're just a worry wart." Misdiagnosis of the problem also is common, deafness being confused by professionals with aphasia, brain damage, mental retardation, or other disabilities.

When the diagnosis actually is made, psychological responses which are virtually universal are set in motion. Parental reactions to having a handicapped child include shock, disbelief, and grief. Guilt feelings are common, especially among parents who have had negative feelings about the pregnancy and the infant. Denial of the handicap also is common on the part of parents, and is often unwittingly fostered by physicians or other professionals unfamiliar with the true ramifications of hearing loss. Such persons, in an attempt to ease the parents' (and their own) discomfort with what is surely a most difficult moment, use overly optimistic statements about the efficacies of hearing aids and speechreading to gloss over the very real differences between being prelingually deaf and having normal hearing.

Coping constructively cannot begin until parents accurately understand the irreversibility of the condition, and its implications. If this understanding and acceptance are not accomplished, if the parents are not guided wisely through the emotional turmoil of this period, the mourning which should be experienced is chronically repressed, and chronic denial is substituted for realistic understanding and effective coping. The resultant inability to take effective measures causes further frustration and anxiety as parent and child struggle through the years to deal effectively with the realities of their mutual communication and emotional needs. The consequences of this denial have been seen frequently by these authors in interviews with parents of deaf children who, in discussing the deafness of fully grown sons and daughters, are frequently brought to tears by grief which has never been fully worked through psychologically (Vernon, 1973). These psychodynamics will continue to be relevant to interactions of the child, the family, and the school.

The Mainstreamed Setting

The term "mainstreaming" has come to represent a wide variety of realities in practice, from full-time placement of individual deaf children in regular classrooms to self-contained classes of hearing-impaired children within public schools, to cooperative programs between residential schools and local public schools. The amounts and types of support services provided in these programs vary in the extreme.

Support Services for Deaf Children

What are the services--for students and faculty--which provide the optimal mainstreaming environment for deaf children?

Communication support. This is obviously first and foremost. Ideally, the teachers in whose classes the deaf child will be placed should be able to use total communication--to simultaneously speak and sign fluently. If this is not the case, the next best alternative is the use of an "interpreter-tutor," as outlined in a model for mainstreaming programs developed in Delaware (Holcomb & Corbett, 1975). In this program an interpreter-tutor is available at all times when the deaf child is with a teacher who is unable to sign. This professional's role is to aid two-way communication by translating into the language of signs the teacher's presentation and the classroom discussion, as well as to translate into voice what is signed by deaf children whose speech is not intelligible to teachers or classmates. In addition, during work periods or after school, tutoring sessions are provided for one-to-one reinforcement of the day's lesson.

In order to foster meaningful communication, sign language lessons should be provided for all relevant faculty, as well as for the hearing students within the system, who should be encouraged, though not forced, to participate in them. Hearing children often find sign language and fingerspelling fascinating and enjoyable, and their willingness to learn them helps assure meaningful social interaction between deaf and hearing classmates.

In addition to having hearing participants gain some sign language skills, the other side of this communication coin must be attended to as well. Deaf children, especially those placed with hearing peers, need to have regular training sessions in developing their speech skills and in auditory training (learning to use whatever hearing they have to maximum benefit), as well as regular checks of their hearing aids and minor adjustments as necessary. If the mainstreaming setting creates greater motivation for the deaf child to use his/her aural and oral skills, this must be capitalized upon through availability of speech teachers, audiologists, and auditory training specialists.

Orientation. Also high on the priority list for support services is an orientation program for staff and students alike. Being confronted with "the unknown" is often difficult and awkward for adults and children who have no experience with deaf individuals. While they may sincerely want to do their best for the child, teachers who have no training in deafness often feel threatened, understandably, by the reality of being responsible for the educational welfare of a deaf student. These feelings of threat can cause resentment or other negative attitudes which, consciously or unconsciously, may impede the teacher's effectiveness with the child. Hearing children can be very cruel in their responses to deaf peers, ridiculing their speech and sign language and otherwise taunting them, if they've had no opportunity to learn to understand them. And, finally, the deaf child also will need orientation which will aid him/her to cope successfully with an environment in which he/she may feel frightened and isolated.

An appropriate orientation program can do much to avoid these potential horrors and help to create a positive prognosis for those involved in the mainstreaming experience. Faculty should be provided with programs covering the following: basics of hearing loss and its ramifications, educational services needed by deaf children, basic sign language, and practical tips on managing the deaf child in the classroom. The opportunity for contact with parents of deaf children and with deaf adults, perhaps in a panel format, can also be helpful. The school administration should discuss in detail with teachers what provisions have been made for helping the faculty to help their hearing-impaired students.

Hearing children should also have some explanation of what it means to be deaf, on a more basic level. Such exercises as wearing earplugs for a day, trying to communicate a sentence or ask a question without using speech, or watching television without sound may help them experience in some small way a bit of the deaf child's world.

Students as well as teachers may benefit from visits by deaf adults, preferably from a variety of professions, to the classroom. Also helpful for this purpose is a recording which explains hearing loss and presents examples of the distortions of speech caused by various types of hearing losses (see Resources section). Group discussions and counseling sessions can provide opportunities for deaf and hearing children (and teachers) to develop sensitivity to each other and smooth the way for meaningful interactions. A final suggestion, if possible, is to arrange for the child to experience some short-term contacts before being formally placed in the classroom. Field trips to schools for the deaf are informative for hearing students and teachers; visits of deaf children to the public school help provide some mutual exposure for both groups to one another. And of course it is helpful and reassuring for the individual deaf child who will be in the class to visit it prior to placement. Many programs begin mainstreaming on a part-time basis, gradually expanding the time the child spends in the classroom until the total time goal is reached, in the belief that this helps to make the transition easier for all involved.

Academic support. Due to the nature of deafness and the language handicap it imposes, deaf children frequently find competing in the public classroom a challenging and stressful task. At the least, tutoring will be helpful and probably required. If an interpreter-tutor is not available, other provisions must be made. Some systems use "resource teachers" or "itinerant teachers" with whom the child has periodic visits for intensive language work and other academic remediation. Such visits must be frequent if they are to be beneficial; thirty minutes with an educational specialist biweekly is quite obviously little more than a token offering of help for the deaf child.

A simple but very helpful service which classroom teachers may provide, especially at the secondary level, is arranging for copies of class notes. A "buddy system" may be set up by pairing the deaf child with a capable and willing hearing classmate, who makes carbon copies of notes taken during class for the deaf student. Teachers simply provide the carbon paper. The teacher may prefer to provide the deaf child with a clear copy of the teacher's own notes, which also is helpful (Vernon & Athey, 1977).

Social support. In all of the attention given to the academic needs of mainstreamed children, their social needs are sometimes overlooked. Schools (both hearing and deaf) have long recognized how the ongoing socialization of students can be enriched in the classroom as well as through extra-curricular activities like scouting, athletics, dances and parties, hobby clubs, and dramatic productions. The availability of these activities is frequently cited as one of the advantages of placing a deaf child in a school for the deaf (Furth, 1973). In such schools, the deaf child is part of a peer group, able to participate fully in clubs and activities and compete on an equal basis with classmates for leadership roles. The benefits for social and emotional growth are obvious for all children, disabled or not. Placing a deaf child in a mainstreamed school requires careful planning to insure that the child has free and open access to meaningful participation in whatever activities are personally appealing. This is a difficult task, to be sure, but without it, a vital part of the educational experience will be denied.

Another advantage offered by a school for the deaf is the opportunity to have extensive interaction with deaf peers, and to learn from and identify with deaf adults as successful role models. Providing for genuine, meaningful interaction with hearing students has its own potential advantages; however, deaf children still need the opportunity to associate with other deaf young people and adults. This interaction fosters understanding of their own deafness and development of the skills needed to cope with it and to accept it (Katz, Mathis, & Merrill, 1974).

Perhaps the experience of one of the authors, which occurred in a recent conversation with a deaf friend, best describes the psychological import of the need for deaf children to associate with other deaf. This woman, now middle-aged, who had been deaf all of her life, was born into a family whose members all had normal hearing, and had always attended hearing schools until she attended a college for the deaf. Throughout her childhood and adolescence she had never met another deaf human being, child or adult. She recalls,

> As far as I knew, I was the only deaf person in the world. I had never seen a grown-up deaf person, and my child's mind drew the conclusion that deafness was terminal. Although it seems ludicrous now, I spent years believing that I would not live to grow up.

One can imagine the trauma this woman experienced in her formative years. School personnel and parents of the mainstreamed child must work together to provide experiences with other deaf persons which prevent such unnecessary anxiety and offer rich psychosocial nourishment, especially for the deaf child whose educational placement does not include numbers of other deaf children and deaf instructors.

Other school support services. In addition to the specialized services discussed, deaf children need to have access to all of the services and personnel normally offered by schools--psychologists, nurses, counselors. If these people cannot use total communication with the deaf child, then the child must be provided access to interpreting services, in much the same way that ramps help provide architectural access for persons in wheelchairs.

The Administration in Mainstreamed Schools

The presence of disabled students in a school often presents administrators with some new roles and decisions.

Dual Lines of Authority

It is helpful for all teachers to have supervisors who can offer them guidance on methods and materials, and this is especially true for teachers who work with specialized populations. School systems establishing programs for disabled students must reconcile this need with the awareness that administrators in individual schools, while they may be quite competent otherwise, often have no training or experience in specific areas of disability. Frequently, school systems seek to resolve this dilemma by establishing a county-wide director of special education, or more specifically of deaf education, who is able to provide more appropriate teacher support and coordination of services. A potential danger exists, however, with such dual lines of supervision; care must be taken that teachers and administrators alike understand the respective responsibilities and authorities of both the in-house (school principal) and district-wide (special education coordinator) positions. Failure to clarify roles and tasks results in confusion, duplication of services, and inefficiency.

Discussions with public school teachers with classes of hearing-impaired children who are also integrated part-time into hearing classes reveal another potential administrative danger zone. Schools may expect the teacher of the deaf, typically called the child's "homeroom" teacher, to prepare and implement the Individual Educational Plan, including arranging for placement in hearing classes and coordinating support services. This often places the homeroom teacher in a trap: accountable for arranging these services with other school personnel but with no administrative authority to do so. The result is often resentment and friction between the teacher and others on the faculty, which is destructive not only to staff cooperation and morale but ultimately to the deaf child's educational programming as well.

If administrators decide to provide mainstreaming in a school system, then they are obligated to commit the time, energy, and finances necessary to provide an optimal atmosphere for its success. Faculty require support services just as students do--specialized media and materials, administrative willingness to lower class ratios, and mechanisms to promote school-parent cooperation, to name just a few. If those in decision-making positions at various levels are unable or unwilling to see that the additional resources required are absolute necessities, not luxuries, then mainstreaming is not a viable option, and the danger of yielding to pressures to mainstream must be avoided (Vernon & Athey, 1977).

The Counselor in the Mainstream Setting

Roles and responsibilities of counselors will vary widely from school to school. Generally speaking, counselors of hearing-impaired children should either have, or be willing to acquire, some degree of understanding of deafness. Ideally, a counselor trained in both mental health and deafness, with fluent communication skills, should be one of the resources available as part of the program. Lacking such a person, it becomes the task of the school's counseling staff to approximate this ideal to the closest degree possible.

Direct Services vs. Environmental Intervention

In addition to needs for counseling in the same areas as hearing children, deaf children have additional counseling needs unique to their developmental disability and to their adjustment to being mainstreamed into a hearing school. Vital to effective counseling is comfortable and effective communication between counselor and client (Patterson & Stewart, 1971). That counselors be highly skilled in communication, therefore, is fundamental to the counseling of deaf children. Public school counselors lacking skills in manual communication must honestly realize that their ability to aid the deaf children in their caseload will be limited largely to environmental intervention. Direct attempts to counsel with the deaf child will be, in all probability, more frustrating than therapeutic; even less verbal methods such as play therapy, psychodrama, or art therapy require ability to communicate.

Counseling through use of an interpreter, though certainly less than ideal, may be tried, but will probably meet with more success in hearing/deaf group sessions than in individual counseling. Consequently, counselors unskilled in manual communication can best direct their efforts to shaping the home and school into more therapeutic milieus, or to helping significant others to understand and accept the deaf child. The counselor, in effect, becomes a child advocate and a change agent, working to help families, teachers, administrators, and special services professionals become a mutually supportive team, sensitive to meeting the child's needs. Several relevant topics have been treated above; additional suggestions which may be helpful in creating an atmosphere of cooperative effort are provided here.

Psychological evaluation. School counselors are often expected to identify children in need of psychological testing and either provide this service or refer the children to other specialists. While this topic cannot be fully treated here, a few general guidelines for psychological testing of the hearing impaired are provided. More in-depth information, including suggested test instruments, is provided in the Vernon and Brown (1964) article.

1. Nonverbal or performance tests must be used in assessing intelligence, rather than tests dependent on language skill. As explained above, many bright deaf individuals have severely impaired English language skills. Consequently, verbal tests produce invalid scores, inasmuch as they test reading and writing rather than intelligence. Many deaf individuals have been misdiagnosed as retarded by psychologists unaware of this.

2. Not all nonverbal tests are appropriate for use with deaf children; they also must not require verbal directions.

3. Scores for preschool and early elementary deaf children tend to be highly unreliable; low scores in particular should be viewed as questionable.

4. There is far more danger that a low IQ score is wrong than a high one, due to the many factors which may lead to a child's not performing well.

5. Tests administered by a psychologist not experienced with the deaf are subject to greater error than those administered by one familiar with deaf youngsters. Fluency in manual communication is a vital skill in testing deaf children.

6. Untimed tests are preferable to timed instruments.

7. Group testing of deaf children should be avoided; at best this may be considered as a screening device (Vernon & Brown, 1964).

Orientation. The task of providing orientation to faculty and students has been discussed above, a task which often falls partially or fully on the counseling staff. To some extent this is appropriate, as these issues carry heavy emotional overtones and contain a large component of sensitivity training. However, the counselor who has no experience with deafness may feel at a loss to handle such a task. It is hoped that the information here, and the resources provided in the final section of this article, may be of some value in enhancing understanding of deafness for counselors confronted with their tasks.

Parent counseling. Working with parents is a normal part of the activities of a school counselor, but may present difficulties for the untrained counselor in working with parents of deaf children. The degree of acceptance and coping skills observed in parents of deaf children extend the full gamut, and untangling parents' verbalizations to uncover the true affective content can be especially difficult for one not well-versed in this area. For example, some parents who realistically accept and manage their child's deafness wish to have the child placed locally in a mainstream setting because of their honest desire to have their child live at home rather than in a residential setting. Others desire enrollment in the public school system because it meets their parental need rather than the need of the child: It lets the parents say that their child is in a local school, not in "a school for the deaf," thus enabling them to satisfy the need to deny the child's disability (Katz, Mathis, & Merrill, 1974).

Counselors will find that most parents of disabled children welcome the opportunity to discuss feelings and receive guidance from understanding, knowledgeable, and accepting counselors. The counselor, however, should be prepared for parents who exhibit defensiveness and hostility. Such behaviors may stem from the basic dynamics surrounding the trauma of diagnosis of deafness described above. A few relevant issues counselors commonly confront are presented here.

Parents who are unable to recognize and accept fully the reality of their child's deafness may be very resistant to suggestions from the school--for example, assertions that they should learn sign language to enable them to communicate with their child. To such parents, use of sign language represents very visible evidence of the child's disability. They would prefer, despite how unrealistic it may be, that the child function orally as "normal" children do (Schlesinger & Meadow, 1972). Parents also commonly need help in understanding their deaf child's language and academic difficulties.

Some parents may express, either actively or passively, substantial hostility toward school personnel, especially those who work in mental health fields. Some of this hostility stems from the simple fact that many persons find psychologists threatening. But often such feelings are legitimate, having developed through years of being shunted from specialist to specialist, receiving misdiagnoses and misinformation from those who are supposedly "the experts." Parents often receive conflicting advice on methods of rearing and educating their deaf child due to the philosophical disagreements among professionals in the field. Although the situation is improving, professionals competent in both deafness and mental health have been a rarity. Thus there are sometimes natural roots for distrust and hostility toward professionals by parents who, in trying to cope with the daily realities of a deaf child, view them as unable to provide adequately the practical, consistent advice that they need.

In addition to helping parents express and work through their feelings about having a deaf child, counselors may also serve as a source of information about deafness and guidance to parents as they are confronted by critical decisions. Parents need access, for example, to complete information about the various communication philosophies, and about educational placement options available to them and their child. Only then is it possible for them to make appropriate choices. Realistically, this may be a difficult task for the public school counselor who has minimal information about and experience with deafness. Such a counselor may find the list of resources in the final section to be helpful. In addition, some practical suggestions are provided here which may be carried out by professionals who do not have extensive training in this specialty (Vernon, 1979).

1. Self-help groups. Groups for parents of disabled children already exist in many areas. Such groups maximize the opportunity for members to express feelings in an accepting, understanding environment, and to receive helpful information and counseling. For low-incidence handicaps such as deafness, or in rural areas, such groups may not be available. In this case, it may be possible to put parents in touch with a family that is successfully raising a deaf child, or an adult who has successfully coped with deafness (Vernon, 1979).

2. Parent institutes. Helpful, especially outside of large population centers, institutes bring parents together from a wide geographic area for a weekend or a week of intensive counseling and information-sharing. Obviously, these programs require residential facilities. (State facilities serving handicapped children are often helpful here.) These institutes should include informative presentations, as well as ample opportunity for parents of newly-diagnosed deaf children to share in the knowledge and experiences of parents of long-term deaf children. The opportunity to meet with deaf adults who have successfully coped with the disability is also vital (Vernon, 1979).

3. Group memberships. For parents unable to participate actively in such self-help groups for whatever reason, some help may be gained through membership in such organizations as the International Association of Parents of the Deaf (see Resources).

4. Reading materials. Counselors may refer parents to, and help them obtain, reading materials such as those listed in the Resources section of this article.

5. Communication training. Many schools serving deaf children, recognizing the value of total communication in both school and home, offer sign language instruction to parents. If this training is not available through your school, possible sources may be other agencies serving the deaf, area churches with deaf members, the local Registry of Interpreters for the Deaf, or deaf adults in your community. A variety of sign language books may be obtained through the Gallaudet College (Washington, D.C.) Bookstore.

Professionals' Reaction to Deafness

Discussions of the psychological dynamics of disability often focus exclusively on the impact on the child and the family. A few final notes are in order here relevant to the affective load for professionals who work with such children.

As touched on earlier in this paper, physicians, counselors, teachers, and others involved with disabled children and their families often share certain emotional responses. Informing parents initially of the actual diagnosis, and through the years of its ramifications, can be an awkward, traumatic situation for the professional as well as for the parent. For persons in the helping professions who are truly committed to paving the road to self-fulfillment for families, confronting the irreversibility of the handicap and the very real impediments it imposes is a source of genuine frustration. This is true for professionals trained in the specific disability, and often even more so for those who are not. Confronting their own limitations (due partially to lack of knowledge and partially to the inadequacies of the current state of the art) may be very threatening, but staying in touch with their own emotional reactions is vital if they are to remain effective. Emotional burnout is common in these disciplines, especially for the people who are "on the line" daily with disabled children. With deafness specifically, the communication barrier, especially for those not fluent in sign language, is another source of frustration. Frustration breeds anger, and anger seeks a target; the result frequently is inappropriate outbursts or more subtle friction among all parties involved, with concomitant breakdown of the mutual support available for the people who need it most. A tremendous service can be offered by the counselor who is able (in addition to the multitude of other responsibilities!) to help all involved (including him/herself) process these inter- and intrapersonal responses effectively.

Recommendations for the Future

Several areas of need for the future from a guidance point of view have already been mentioned in previous sections of this paper. A few additional thoughts are listed here.

An area of great need is improvement of the quality and quantity of mental health professionals in the field of deafness. Although the situation is looking better, a discouragingly large proportion of persons now doing this type of work still have expertise in either deafness or mental health, but not in both disciplines. Research and development are critically needed in the area of the psychology of deafness. A primary recommendation, then, is for more training, and for more hiring, of mental health and deafness specialists at both preventive and treatment levels (Vernon, 1971). Such persons should be available in schools serving deaf children, including mainstreaming schools.

A second area of need is for research to produce accurate data on all aspects of the realities of mainstreaming and its influences on all involved. Mainstreaming remains a highly controversial issue; the profession needs studies concerning the effects of mainstreaming on academic achievement, social/emotional development, interpersonal relationships, self-concept, attitudes of disabled and nondisabled persons toward each other, to name but a few.

In their roles as child advocates, counselors are perhaps the most logical persons to assume responsibility for seeing that each deaf child is considered as an individual. Being deaf does not neutralize these children's differences, and caution must be exercised to assure that decisions on services and educational placement are made in light of the given child's strengths and needs, not on the basis of political expediency, financial advantage, or denial of the handicap and its ramifications.

Finally, two facets of guidance needed for deaf students not touched on in this paper are vocational/career guidance--helping deaf students to gain not only vocational skills but also vocational maturity, and self-knowledge--providing opportunities for deaf children to explore their own deafness, their feelings about being deaf, and their interactions with hearing persons--and to develop practical skills to cope with the disability.

Summary

The prognosis for success for deaf children in mainstreaming programs depends upon a complex interaction of factors in the child, the family, and the program. The school counselor can play a vital role as child advocate throughout all stages of the educational process, and may help to make the difference between a mainstreaming program which represents a stressful and inappropriate option, or one which offers the child the maximum possible opportunity for educational and social/emotional growth within the given setting.

RESOURCES

(Note: The resources marked with an * are especially helpful for parents.)

Organizations

Convention of American Instructors of the Deaf
5034 Wisconsin Avenue, N.W.
Washington, D.C. 20016

Publications: American Annals of the Deaf - professional journal in education of the deaf.

American Annals of the Deaf Directory - an invaluable reference of schools, agencies, and services in deafness, published annually in April.

*Registry of Interpreters for the Deaf
P.O. Box 1339
Washington, D.C. 20013

Professional organization providing interpreting services. Contact the national office for location of local chapters.

*International Association of Parents of the Deaf
814 Thayer Avenue
Silver Spring, Maryland 20910

A self-help organization of, by, and for parents of deaf children.
Publication: The Endeavor

National Association of the Deaf
814 Thayer Avenue
Silver Spring, Maryland 20910

The largest national organization of deaf persons, active in advocacy of deaf rights, etc. Operates a bookstore with publications on deafness. Booklist may be requested.
Publication: The Deaf American

Junior National Association of the Deaf
Gallaudet College
Washington, D.C. 20002

Promotes deaf awareness and leadership in deaf youth; runs national summer camps for this purpose. Local chapters are usually located at state schools. Contact the national office for information.

American Deafness and Rehabilitation Agency
814 Thayer Avenue
Silver Spring, Maryland 20910

An organization of rehabilitation counselors, social workers, psychologists, audiologists and professionals in fields allied with provision of services to deaf adults.
Publication: Journal of Rehabilitation of the Deaf

Division of Vocational Rehabilitation

Local offices of this state-administered program available in the telephone directory. This agency serves all disabilities, including deafness, with the primary goal of promoting employability and job placement.

*State Schools for the Deaf

Often the richest source available for information and specialized personnel in deafness. These schools are administered by agencies which vary from state to state. To find the location of your state's school, contact the State Department of Education. The American Annals Directory (listed above) includes a complete state-by-state listing of residential and day schools.

Gallaudet College
7th and Florida Avenues, N.E.
Washington, D.C. 20002

Several divisions of this college for deaf persons may be helpful to parents and professionals working with hearing-impaired children.

*College Bookstore - carries an extensive inventory of books and materials on deafness and sign language, including children's books illustrated with sign language representations of the written text. Booklists and order forms may be requested.

*Public Service Programs - provides a variety of programs and printed materials on deafness, including "Summer Learning Vacations" for families of deaf children.

Additional Publications and Media

Captioned Films for the Deaf
U.S. Office of Education
Bureau of Education of the Handicapped
Division of Media Services
400 Maryland Avenue, S.W.
Donohue Building, Corridor 4800
Washington, D.C. 20202

Provides captioned educational and commercial films for viewing by deaf students and adults. Catalogue available on request.

"Getting Through" (Zenith, 1971)
Zenith Radio Corporation
6501 West Grand Avenue
Chicago, Illinois 60635

A recording designed to explain hearing loss and provide examples of speech as perceived by those with impaired hearing.

Total Communication Laboratory
Western Maryland College
Westminster, Maryland 21157

A series of films on various aspects of deafness, available in captioned and noncaptioned versions. Topics include the following:

*Listen - general introduction to hearing loss.
*Total Communication - examination of this philosophy, especially its educational implications.
*We Tiptoed Around Whispering - parental and family reactions to diagnosis of the child's deafness.
*Swan Lake - conversations with deaf teenagers on their attitudes, goals, and feelings about their deafness.
*Services for Deaf Children
Services for Deaf Adults

Recommended Readings

Holcomb, R. R., & Corbett, E. E., Jr. *Mainstream - the Delaware approach.* Newark, DE: Newark School District (Sterch School), Chestnut Hill Road, 1975.

*Jacobs, L. A deaf adult speaks out. Washington, D.C.: Gallaudet College Press, 1974.

Highly readable presentation of issues relevant to deafness and deaf education from the perspective of a successful deaf adult.

*Katz, L., Mathis, S. S., III, & Merrill, E. C., Jr. The deaf child in the public schools. Dansville, IL: Interstate Printers and Publishers, Inc., 1974.

A handbook with extensive practical information on mainstreaming the deaf child helpful to parents and educators.

*Mindel, E., & Vernon, M. They grow in silence. Silver Spring, MD: National Association of the Deaf, 1971.

Information on the deaf child and the family as well as numerous other aspects of deafness.

Moores, D. Educating the deaf, psychology, principles, and practices. Boston: Houghton Mifflin Company, 1978.

*Spradley, T., & Spradley, J. Deaf like me. New York: Random House, 1978.

The personal account of a family raising a deaf child; highly recommended for parents and professionals.

REFERENCES

A look at American sign language. Washington, D.C.: Public Service Programs, Gallaudet College, undated.

Boatner, E. B. *The need of a realistic approach to the education of the deaf*. Paper delivered to the joint convention of the California Association of Parents of Deaf and Hard of Hearing Children, California Association of Teachers of the Deaf and Hard of Hearing, and California Association of the Deaf, 1965.

DiFrancesca, S. *Academic achievement test results of a national testing program for hearing impaired students, United States: Spring 1971*. Washington, D.C.: Office of Demographic Studies, Gallaudet College, 1972.

Furth, H. *Deafness and learning, a psychological approach*. Belmont, CA: Wadsworth Publishing Company, Inc., 1973.

Holcomb, R. K., & Corbett, E. E., Jr. *Mainstream - the Delaware approach*. Newark, DE: Newark School District (Sterch School), Chestnut Hill Road, 1975.

Jacobs, L. *A deaf adult speaks out*. Washington, D.C.: Gallaudet College Press, 1974.

Katz, L., Mathis, S. S., III, & Merrill, E. C., Jr. *The deaf child in the public schools*. Dansville, IL: The Interstate Printers and Publishers, Inc., 1974.

Lowell, E. L. *John Tracy Clinic research papers*, III, V, VI, VII. Los Angeles: John Tracy Clinic, 1957-1958.

Lowell, E. L. *Research in speechreading: Some relationships to language development and implications for the classroom teacher*. Report of the Proceedings of the 39th Meeting of the Convention of American Instructors of the Deaf, 1959, 68-73.

Martin, F. N. *Introduction to audiology*. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1975.

Meadow, K. Early manual communication in relation to the deaf child's intellectual, social and communicative functioning. *American Annals of the Deaf*, 1968, *113*, 29-41.

McClure, W. J. Current problems and trends in the education of the deaf. *Deaf American*, 1966, *18*, 8-14.

Mindel, E., & Vernon, M. *They grow in silence - the deaf child and his family*. Silver Spring, MD: National Association of the Deaf, 1971.

Moores, D. *Educating the deaf, psychology, principles, and practices*. Boston: Houghton Mifflin Company, 1978.

Patterson, C. H., & Stewart, L. G. Principles of counseling with deaf people. In A. E. Sussman & L. G. Stewart (Eds.), *Counseling with deaf people*. New York: New York University School of Education, 1971.

Schlesinger, H., & Meadow, K. *Sound and sign*. Berkeley, CA: University of California Press, 1972.

Stuckless, E. R., & Birch, J. W. The influence of early manual communication on the linguistic development of deaf children. *American Annals of the Deaf*, 1966, *111*, 452-460, 499-504.

Trybus, R., & Karchner, M. School achievement scores of hearing impaired children: National data on achievement status and growth patterns. *American Annals of the Deaf Directory of Programs and Services*, 1977, *122*, 62-69.

Vernon, M. Counseling the parents of birth-defective children. *Postgraduate Medicine*, 1979, *65*(3), 197-200.

Vernon, M. Current status of counseling with deaf people. In A. E. Sussman & L. G. Stewart (Eds.), *Counseling with deaf people*. New York: New York University School of Education, 1971, 30-42.

Vernon, M. Fifty years of research on the intelligence of deaf and hard of hearing children: A review of literature and discussion of implications. *Journal of Rehabilitation of the Deaf*, 1968, *1*, 1-11.

Vernon, M. Psychological aspects of the diagnosis of deafness in a child. *Eye, Ear, Nose and Throat Monthly*, 1973, *52*, 60-66.

Vernon, M. Sociological and psychological factors associated with hearing loss. *Journal of Speech and Hearing Research*, 1969, *12*(3), 541-563.

Vernon, M., & Athey, J. The Holcomb plan, a creative approach to mainstreaming deaf and hard of hearing children. *Instructor*, 1977, *86*, 136-137.

Vernon, M., & Brown, D. A guide to psychological tests and testing procedures in the evaluation of deaf and hard-of-hearing children. *Journal of Speech and Hearing Disorders*, 1964, *29*(4), 414-422.

Vernon, M., & Koh, S. D. Early manual communication and deaf children's achievement. *American Annals of the Deaf*, 1970, *115*, 527-536.

Vernon, M., & Koh, S. D. Effects of oral preschool compared to early manual communication on education and communication in deaf children. American Annals of the Deaf, 1971, 116(6), 569-574.

5 GUIDANCE AND COUNSELING FOR THE VISUALLY HANDICAPPED

Susan Jay Spungin

Susan Jay Spungin is the National Consultant in Education with the American Foundation for the Blind in New York City. She has had extensive experience in working with national governmental and voluntary agencies as well as with local specialized agencies, educational systems, and colleges and universities concerned with improving services to visually handicapped children and youth. She has published as well as conducted workshops and seminars regarding the education of the visually handicapped in the following areas: parent education, assessment, sex education, career education, psychosocial development, teacher training, and competency-based curriculum. She has also served as a lecturer at Hunter College, Fordham University, and Teachers College, Columbia University.

GUIDANCE AND COUNSELING FOR THE VISUALLY HANDICAPPED

Susan Jay Spungin

This chapter dealing with guidance and counseling for the visually handicapped discusses the characteristics and needs of the visually handicapped population including the following areas: genetic counseling, sex education and psychosocial development, counseling for parents of school-aged and preschool visually handicapped children, educational and vocational counseling, rehabilitation counseling, and counseling services available for adults. Issues relating to legislation and mainstreaming are dealt with in light of the Education of All Handicapped Children Act, PL 94-142. The chapter concludes with a list of recommendations and resources for persons who work with visually impaired individuals, and a statement of imperatives for the future if the unique needs of this population are to be adequately met.

Definition of Terms

Counseling has been defined in various terms and by many experts. Gustad (1953) has written that

> Counseling is a learning oriented process, carried on in a simple, one-to-one social environment in which a counselor, professionally competent in relative psychological skills and knowledge, seeks to assist the client to learn more about himself, to know how to put understanding into effect in relation to clearly perceived realistically defined goals to the end that the client may become a happier and more productive member of his society. (p. 27)

The broadness of this definition allows one to see clearly that many individuals have enormous potential for impact on a visually handicapped individual's life from birth through adulthood.

What is really meant by a "visually handicapped individual"? The most commonly accepted definition in the United States is an individual whose visual acuity is 20/200 or less in the better-corrected eye, or whose peripheral vision is reduced to an angle of 20 degrees or less.

This legal definition of blindness is often considered from an economic rather than a functional perspective since a person with this degree of visual loss is entitled to special federal money to help defray costs for various services. The functional definition of blindness states that an individual is entitled to service when his/her visual impairment is severe enough to be considered a handicap. Regardless of which definition one uses, we are talking about a relatively small population of people who generally have some vision.

Statistics in the field of blindness are for the most part "guesstimates" and vary according to the age of the population considered. For instance, an accepted statistic in the field of education is that one out of every thousand school-age children has a visual handicap severe enough to require special educational services. This is only 1% of the total school-age handicapped population, and such individuals have a visual acuity of 20/60 or 20/70 to total blindness. Consequently, the visually handicapped population is small in number and scattered over a large geographic area, making service delivery difficult and costly. The estimated figure for the total visually handicapped population is approximately 1.4 million, with 65% of this group over the age of 65.

It is as important to know the age of onset of the visual loss as it is to understand the type of loss as it relates to function. Both training and the kinds of methods used when working with an individual vary according to whether the condition occurred at birth (congenital) or later in life (adventitious).

Genetic Counseling

Genetic counseling is a growing area; and due to recent experimental research efforts by geneticists as well as monitoring systems and prenatal diagnosis, some answers are available. Carpenter (1977-78) describes the case of a couple who were warned that if they were to have a baby, there was a 50-50 chance of the baby having cataracts and/or myopia.

> Angie and George took that 50-50 chance with full knowledge of the possible consequences because they wanted children. Adoption was suggested. "But we want our own!" said Angie, "and

> if it is blindness that is a possibility, I think we can handle it." (p. 169)

Genetic counseling is done by a medical geneticist or genetic counselor who can communicate with parents with great tact and sympathy. There is much to consider: possible feelings of guilt in the parents who may think there is something wrong with them; threats to masculinity and femininity; deeply ingrained folk myths which cushion families from reality; the privacy to be respected when dealing in other peoples' lives; and, general rebellion.

Decisions about whether or not to have children or to adopt children, whether to seek prenatal diagnosis through amniocentesis, whether to abort or continue a pregnancy, rest solely with the couple directly involved. A genetic counselor may outline the probabilities and the risks involved in child-bearing; but if, like Angie and George, the couple decide to go ahead with the pregnancy and delivery, they have a right to do so. A 50-50 chance includes an equal chance of good fortune or bad. Education of the public regarding available scientific knowledge is a primary requirement if we are to effect changes which are basically cultural in nature. There are also specific areas which hold a special interest for blind persons. Genetic counselors might attach minimal importance to sex education programs for sighted youngsters, yet this problem ranks high among those troubling visually handicapped boys and girls.

Sex Education and Psychosocial Development

Schools and agencies serving the visually handicapped are recognizing the need for programs in sex education and family life. This area has long been neglected, leaving the visually handicapped young person to gain information (or more frequently, misinformation) from peers, both sighted and blind.

The physical growth process is not affected directly by visual impairment. Lack of vision, however, does retard the development of physical skills, especially those learned by imitation. Walking may be delayed. Childhood activity skills, such as skipping and jumping rope, may require more direct teaching. The role of vision in the imitative process is recognized as essential for developing childhood motor activities, and direct intervention is often used to teach needed physical skills. Movement education has been found to be particularly beneficial for blind children. However, such training is often overlooked for the adolescent and there is a tendency for parents and teachers to neglect teaching physical and motor activities that are part of adolescent life. The blind adolescent and young adult may need direct teaching to acquire skills such as dancing, lighting and holding a cigarette, and, particularly during the stage of rapid growth, managing awkward limbs.

Visually handicapping conditions also have an indirect effect on physical or personal appearance. Children learn how they look to others through mirrors, and lack of vision deprives the person of this very valuable resource. Experiences in feeling clothing, facial features, body structure, or posture may be necessary to provide the blind adolescent in particular with some notion of how he "looks" relative to his peers. It is unfortunate that social taboos against touching are applied to educational experiences for the visually handicapped and blind since an important area of access to the object world is through the sense of touch.

The effects of blindness are probably most serious in cognitive development. Concepts such as color, three-dimensional space, and perspective can never be grasped because they cannot be experienced, even imperfectly, through other sensory modalities. Learning about the object world must be achieved tactually. Even though an object may be experienced through touch, certain characteristics integral to complete understanding may not be--for example, a bird in flight.

Educators working with visually handicapped children attempt to utilize the real object, if possible; if not, then models or replicas, and if these are not available or appropriate, verbal descriptions are used to communicate some notion of the concept being taught. To date, counselors or teachers have experienced little success in adapting two-dimensional pictures to three-dimensional objects for the sense of touch. Models are deficient in communicating the texture of an object, such as the feel of living human skin. Thus characteristics which are an inherent part of a concept may not be communicated clearly through models.

The foregoing discussion identifies a dilemma in the development of programs in sex education and family life. Ideally, schools and agencies should use live persons for demonstration rather than models, which are deficient in conveying texture or life even when constructed to scale. However, few schools and agencies would or could adopt such a program because American societal pressures are too strongly against such a practice. Some parents of preschool blind children who feel comfortable with themselves and their own sexual feelings may be encouraged to begin at the toddler stage to have children explore their own bodies, as well as those of family members in natural situations, in order to learn of physical sex differences and to develop a sense of body awareness. Without such direct contact, blind adolescents experience confusion and, as one male adolescent observed, he knows what a girl's breasts are but doesn't know where they are.

Society attaches a significance to blindness that spreads to the individual. As a dependent and visible impairment, blindness arouses pity and sympathy. Social skills and experiences with sighted peers are, unfortunately, often neglected in the educational process. Some social skills must be taught to the blind child, though they frequently are not because parents and teachers tend to overlook their contribution to ultimate adult adjustment. Blindness also deprives the person of a critical avenue of social interaction: nonverbal communication. Much is communicated between and among persons without words. Approval is expressed by a smile, disapproval by a frown; attention is attracted to oneself by body and facial demeanor, solicited by a wink or meaningful glance. However, little has been done to explore possible forms of nonverbal communication that can be employed by blind persons in their social interaction with both blind and sighted peers (Scholl, 1974).

The time has come when society is beginning to think of sex as something we are rather than something we do. Consequently, most educators today realize that sex education is a meaningful and necessary part of the educational curriculum for all children. However, there was a time not too long ago when the subject of sex education for visually handicapped youngsters was unheard of and the social treatment of this population in terms of their sexuality was one of isolation, neuterization, and dehumanization. Today, visually handicapped young people are growing up in a sexually-oriented society, bombarded as all of us are by the media and our peers with a constant barrage of sexually-oriented ideas, information, and misinformation. The visually handicapped youngster must learn to cope with a society which is becoming increasingly more open and candid in dealing with sexual information and attitudes.

Parent Counseling

In working with parents of children who are blind, the counselor is confronted with a condition which is often final and irreversible. The only avenues of exploration, then, are attitudes, values, and behavioral patterns surrounding the disability of blindness; and factors that impede communication and understanding and/or create a social and emotional handicap.

The counselor is frequently made aware that blindness is regarded by the parents and the family as an active, intrusive force, operating to limit not only the child's area of maneuverability but theirs as well--almost as if it were a distinct entity with a life and demands of its own. Instead of a family which includes a blind person in its midst, it becomes a "blind" family. Consciously or unconsciously, the family develops a variety of behavioral techniques to ward off what it holds to be the effects of the child's affliction, designed in some way to negate the handicapping condition. What are some of the components of such techniques and how do they function within the structure of the parent-child relationship?

Over-protectiveness is one parental attitude which, although it may have some realistic basis, in the long run can produce negative results. The counselor must certainly acknowledge parents' genuine concern that their blind children might come to physical harm were they to move too fast or in the wrong direction. No less genuine is their wish to spare their children real or fancied incidents resulting from insensitivity or misunderstanding on the part of their peers. However, too often this justifiable concern is magnified to exaggerated proportions. Children are further handicapped when, with a constricted universe to begin with, they are not allowed to explore unaided the wonders that are contained within their auditory and tactile orbit. The attention focused upon every aspect of their behavior attaches a special value to their helplessness which becomes a powerful manipulative tool for making demands, exerting pressure, and gaining advantages and privileges in daily interaction with the family and others around them (Telson, 1965).

The situation can be further complicated if there are siblings in the family who exclude the blind youngster from their world and are, in turn, excluded from his or hers. The parent may experience divided allegiance, may feel pressured into partiality towards one or another, may be inconsistent and demanding.

In any family, even those considered well-adjusted and healthy, stress periods occur. In the family with a handicapped child, certain stress periods have been identified and discussed in the literature. Murray (1959) was among the first to indicate the need for lifelong counseling, recognizing that crises will continue to occur. Several good lists of crisis periods have been documented. Hastings' (1960) list of seven is important and is frequently cited: (1) birth, (2) developmental delay, (3) school entrance, (4) adolescence, (5) vocational planning, (6) death of a parent, and (7) institutional placement.

Getting a parent involved in community resources that can assist the growth and development of the blind child is a very productive way to channel a family's frustration and anxieties about their child. Parent groups for parents of visually handicapped are growing across the nation. A national list is available which can be obtained free of charge from the American Foundation for the Blind, 15 West 16th Street, New York, N.Y. 10011. Parent groups are valuable not only as a means of sharing experiences but also as a powerful vehicle for parent education. With the passage of the Education of All Handicapped Children Act in 1975, parents must be made aware of their rights regarding the individualized educational program (IEP) plan for their child. This is especially true if they are to be child advocates fighting for "an appropriate education" in the "least restrictive environment." Due process procedures are part of the law specifically in response to parents' rights and each parent should become knowledgeable about these procedures and how they function in their state.

Educational Counseling

Educational counseling should form an integral part of the counselor's broader focus on helping parents give their children guidance within a sound, growth-producing emotional environment. Of paramount importance to a productive client/counselor relationship is that the counselor be familiar with the variety of educational programs and resources available at all age levels. As the visually handicapped child moves through his/her educational years, the counselor should take on the role of a coordinator of services. Far too often, however, the counselor is called in only during critical times, as mentioned earlier by Hastings (1960).

Community public day school programs for the visually impaired have grown rapidly over the entire nation during the last 35 years. In many cases, their development has been the result of a long, careful planning process by educators of visually-impaired children. Other programs have evolved because of the expressed desires of individual parents to keep their children at home. Presently, the pattern is such that in each area programs operate in an unique fashion depending upon geography, population, administrative policy, and teachers' own perceptions of their role.

The education of blind with sighted children in public day school programs is predicated upon the basic philosophy that all children have a right to remain with their families and in their communities during the course of their education; that a visually-impaired child has a right to be counted as one of the children of the family and of the community; and that both the family and the community have an obligation to provide for the blind child, as a minimum, the equivalent of what he/she might have had if sighted.

A variety of organizational patterns or plans is often necessary for developing a complete educational program for visually-impaired children as well as procedures to assure that each child will be placed in or transferred to the particular program best suited to his/her needs at any given time. Organizational plans developed for these children most frequently include residential schools, special classes, resource rooms, itinerant teachers, and teacher consultants.

It is important to note when listing the various educational programs designed to serve the visually handicapped that residential schools are clearly among the alternatives available. Two phrases in the Education of All Handicapped Children Act require that persons responsible for placement of visually handicapped children consider all programming variations and select the one(s) suited to the individual child's needs. These two phrases are "least restrictive alternative" and "appropriate educational program." No person should be so naive as to think that *least restrictive alternative* automatically means placement in a community public school program. For if one meets the requirements implied in the phrase *appropriate educational programming*, the public school program without the proper support services and special educational personnel could be the most restricted educational environment for the child. Residential placement might thus be the most appropriate placement for a prescribed period of time. At no time should different educational program services available to the visually handicapped child be viewed in isolation or as an either/or proposition. All programmatic patterns might be feasible at various times in a child's development, and the spectrum of educational programmatic alternatives should be treated as a continuum which always must include the possibility of residential school placement.

The question is not whether a blind child is in a resource room, an itinerant program, or at a residential school, but whether the educational program in which the child is placed is going to fulfill his/her educational needs and assist the child to achieve a lifestyle that is satisfying to self and to others.

The "mainstreaming" process without appropriate support personnel trained in working with the visually handicapped is antithetical to the intent of PL 94-142. During the school years, therefore, the teacher trained to work with the visually handicapped is one of the most important professionals in the child's life. The role of the teacher of the visually handicapped is in a period of transition. In regard to that role, the future promises to be a potentially critical period in teacher preparation programs and state teacher certification requirements, as well as in the development of education program models designed to serve a geographically-dispersed, low-incidence, handicapped population.

The professional verbiage of the day espouses generic service systems--supposedly to minimize duplication of programming for all exceptional children. Would that the term "generic programming" for our handicapped would soon become a process in special education to be wisely applied. However, far too often we are finding the bases for the generic programmatic approach to be based on economic considerations rather than on educational soundness. An example of the problems created by this approach can be found by examining some state teacher certification procedures in special education. In some states one currently finds that certification to teach the visually handicapped is part of an overall credential to teach the physically handicapped. This trend toward more broadly defined procedures for awarding credentials deserves close scrutiny to ensure that the special skills essential for teaching the visually handicapped school-age population do not become lost, or glossed over as being nice but not necessary.

The very early history of integration or mainstreaming in the field of special education for the visually handicapped had to overemphasize blind children's similarities to nonhandicapped children rather than their differences in order for public school personnel to accept such children within their school systems. As understandable as this approach is, it no longer serves us well. Educators of the visually handicapped as well as some visually handicapped children themselves have done such an excellent job of selling the idea of integration that both the need for special professional expertise and the special needs of the visually handicapped population have become blurred, and in some cases totally ignored. It is time for the profession to step back and articulate the unique differences of the visually handicapped child and the special professional and administrative supports required in order to realize the true intent of PL 94-142 in demanding appropriate educational programming.

The unique educational needs of the visually handicapped vary according to age and the degree of visual loss but include development of the following specific areas:

1. Communication. This includes skills in braille reading and writing, listening, handwriting, the effective use of readers, typing, verbal and nonverbal language, the efficient use of remaining vision with or without optical aids when reading either regular or large print materials, the use of the optacon which converts inkprint into raised letters, the use of the abacus and talking calculator.

2. Orientation and mobility. This area involves the process of independent movement. For the older child three methods of traveling are available and can be taught by a professionally trained orientation and mobility instructor. The three methods available are (a) the sighted guide, (b) the dog guide, and (c) the prescription cane.

3. Daily living and socialization skills. These are skills which teach the student the value and practice of self-maintenance encompassing all the details of daily life: personal hygiene, selecting and maintaining one's wardrobe, eating, cooking, and in general, presenting an appearance that is socially acceptable.

All of these skills should be taught from preschool years throughout the grades by people who have completed recognized programs designed to train teachers to work with visually handicapped children and youth. The competencies expected from graduates of these 27 teacher training programs are numerous, and usually requires attainment of a Master-level degree program (Spungin, 1977).

Vocational Guidance

With a broader emphasis on higher education, increasing numbers of visually handicapped high school graduates are seeking admission to institutions of higher learning. For many such students, the transition from high school to college represents more than a simple transfer from one educational institution to another. Visually handicapped students also must adjust to a whole new set of norms and experiences within a relatively short time. They must establish themselves as independent units within what is usually a large and complex collegiate community and, simultaneously, meet the new social and academic demands placed upon them.

To overcome some of these difficulties, colleges throughout the country have developed orientation programs that have as their basic theme preparation of the visually handicapped student for integration into the college community. The curricula of these programs differ depending on how each perceives the roles of teachers, rehabilitation counselors, college administrators, and soon-to-be college students. Some of the major differences involve location of the program, length of time needed to complete the program, and emphasis placed upon specific needs of visually handicapped students. Course content varies from practice in effective study methods to varied emphases on communicative and social skills. The curricula of precollege orientation programs reflect the need to make up for the failures of previous academic settings through remediation as well as through developing many of the psychosocial and academic skills that the student should already possess (Spungin, 1975).

The area of psychosocial development and the visually handicapped has received much attention recently since many of the reasons why visually handicapped fail in both higher education and in the employment market are due not to poor academic training but to poor training in social skills.

In order to assess clients' readiness to enter or re-enter the world of work, many factors need to be considered. First, their readiness will be affected not only by their level of motivation but also by factors such as the labor market, transportation, mobility, physical and emotional adequacy, intelligence, aptitude, skill acquisition, and job availability (Wilson, 1974).

Unfortunately, far too often appropriate vocational counseling for visually handicapped youth begins in their late teens, and in many cases not until graduation from high school. Although the concept of career education has grown across the country, very little of its impact can be found in educational services for the visually handicapped. Vocational and preschool counseling for parents of visually handicapped children remain the two areas of greatest need.

Rehabilitation

It has been said that individuals who experience a visual loss at an early age, if properly served, should require no rehabilitation services. Unfortunately, many visually handicapped youngsters have not received the necessary special education services described earlier and thus require basic rehabilitation programs upon graduation from high school. This, of course, is especially true of the newly-blinded client who has to cope not only with the acquisition of new skills but also with the tremendous emotional impact of a visual loss.

Reverend Thomas J. Carroll (1961) has stated in dramatic terms the impact of a visual handicap by listing 20 losses that an individual suffers. He describes these particular areas of loss in the following terms:

1. Physical integrity
2. Confidence with remaining senses
3. Reality contact with environment
4. Visual background
5. Light security
6. Mobility
7. Techniques of daily living
8. Ease of written communication
9. Ease of spoken communication
10. Informational progress
11. The visual perception of the pleasurable
12. The visual perception of the beautiful
13. Recreation
14. Career, vocational goal, job opportunity
15. Financial security
16. Personal independence
17. Obscurity
18. Social adequacy
19. Self-esteem
20. Total personality organization

Reverend Carroll further states that the rehabilitation and restoration process must address all 20 losses and attempt to restore psychological security, basic skills, ease of communication, appreciation, occupation and financial status, and the whole personality. Although there are special problems with different age groups and variations in accordance with the extent of visual loss, rehabilitation must include all of the above components in order for the program to be effective.

Recommendations

The following recommendations are offered to those who would assist the blind in their growth and development:

1. Be an advocate for visually handicapped individuals by assuring that all appropriate state laws are sensitive to their needs and are implemented justly.

2. Educate parents, teachers, administrators, and significant others as to existing community resources for the visually handicapped as well as help to develop those necessary services not presently available such as volunteer readers and/or braillists, or home visitors to help the newly-blinded adult with shopping or other tasks.

3. Insist that there be appropriate special education support personnel trained in working with the visually handicapped in schools in order to guarantee that their unique needs are met.

4. Monitor the existing and the future development of training programs in guidance and counseling to insure that the needs of the visually handicapped client are included in the curriculum.

5. Be familiar with the location and resources of the following organizations:

a. American Foundation for the Blind, Inc.
15 West 16th Street
New York, New York 10011
(212) 620-2000

Provides a wide variety of services for the visually handicapped person, the public, and the professional. Promotes the development of educational, rehabilitation, and social welfare services for blind and multiply handicapped children and adults. Programs for the partially sighted are included in educational services.

Conducts and stimulates research to determine the most effective methods of serving visually handicapped persons.

Provides professional consultation to governmental and voluntary agencies. Conducts agency and community surveys to assist in the expansion and improvement of specialized services.

Conducts institutes, workshops, and training courses for professional personnel. Provides legislative consultation.

Operates the M. C. Migel Memorial Library, a special reference library on blindness. Publishes books, monographs, leaflets, and periodicals in conventional print, recorded, and braille forms. Manufactures talking books. Develops, manufactures, and sells special aids and appliances for use by blind persons. Has public education program.

b. Association for Education of the Visually Handicapped
919 Walnut Street
Philadelphia, Pennsylvania 19107
(215) 923-7555

Formerly the American Association of Instructors of the Blind. A membership organization open to persons professionally concerned with or interested in the education, guidance, vocational rehabilitation, or occupational placement of visually handicapped persons. Assists in efforts to improve material and methods of teaching visually handicapped persons, and to expand their opportunities to play an active role in society.

c. American Association of Workers for the Blind, Inc.
1511 K Street, N.W.
Washington, D.C. 20005
(202) 347-1559

A membership organization open to persons and agencies interested in the welfare of blind and visually impaired persons. Assists in the promotion of all phases of work for blind and visually impaired persons. Maintains a library. Operates a job exchange and reference information center. Provides for professional liability insurance. Certifies rehabilitation teachers and orientation and mobility specialists. Works on national, regional, and local levels. As of January, 1977, operates in 6 regions with 31 chapters having members in 45 states, the District of Columbia, Canada, Guam, and Germany.

d. Division for the Visually Handicapped
Council for Exceptional Children
1920 Association Drive
Reston, Virginia 22091
(703) 620-3660

A professional organization of teachers, school administrators, and others concerned with children who require special services. Publishes periodicals, books, and other materials on teaching the exceptional child.

e. National Society for the Prevention of Blindness, Inc.
79 Madison Avenue
New York, New York 10016
(212) 684-3505

Through state affiliates, conducts a program of public and professional education, research, industrial, and community services to prevent blindness. Services include promotion and support of local glaucoma screening programs, preschool vision testing, industrial eye safety, collection of statistical and other data on nature and extent of causes of blindness and defective vision, improvement of environmental conditions affecting eye health in schools and colleges, and dissemination of information on low vision aids and clinics.

f. American Printing House for the Blind, Inc.
1839 Frankfort Avenue
Louisville, Kentucky 40206
(502) 895-2405

National organization for the production of literature and the manufacture of educational aids for the visually handicapped. Since 1879, through the Federal Act "To Promote the Education of the Blind," receives an annual appropriation from Congress to provide textbooks and educational aids for all students attending schools and/or special educational institutions of less than college grade. Through funds donated by the public, publishes braille and talking book editions of the Reader's Digest, and a weekly talking book edition of Newsweek Magazine.

Publishes braille books, music, and magazines; large-type textbooks; talking books and magazines; cassette tapes; and educational tape recordings. Manufactures special educational aids for blind and visually handicapped persons. Maintains an educational research and development program concerned with not only educational procedures and methods, but also the development of educational aids.

Imperatives for the Future

The greatest need of the visually handicapped presently and in the future is for trained personnel both at preservice and inservice levels

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in the area of guidance and counseling. If clients were served at an early age, much of the rehabilitative type of counseling services would be unnecessary. An imperative for the future is general public education as well as sensitization of those professionals and significant others that impact on the life of the visually handicapped. In the past services for the blind have tended to overemphasize clients' similarities rather than differences. As understandable as this approach was, it no longer serves us well since it blurs, or totally ignores, the need for special professional expertise as well as the special needs of the visually handicapped population. If the unique needs of this population are to be met, the profession must clearly spell out the differences unique to the visually handicapped and the special professional and administrative supports required to respond to them.

REFERENCES

Carpenter, P. Genetic counseling and families of the visually impaired. The Sight Saving Review, Winter 1977-78, 167-171.

Carroll, Rev. T. J. Blindness: What it is, what it does and how to live with it. Boston: Little, Brown and Company, 1961.

Gustad, J. W. The definition of counseling. In R. F. Berdie, Roles and relationships in counseling. Minneapolis: University of Minnesota, 1953.

Hastings, M. The social worker's role in helping families of mentally retarded children meet crisis points in a multidisciplinary approach to the diagnosis and treatment of mental retardation. Johnstone Bulletin, 1960, 2, 58-63.

Murray, M.A. Needs of parents of mentally retarded children. American Journal of Mental Deficiency, 1959, 63, 1078-1088.

Scholl, G. T. The psychosocial effects of blindness: Implications for program planning in sex education. The New Outlook for the Blind, May 1974, 201-209.

Spungin, S. J. Precollege programs for blind and visually handicapped students. New York: American Foundation for the Blind, 1975.

Spungin, S. J. Competency based curriculum for teachers of the visually handicapped: A national study. New York: American Foundation for the Blind, 1977.

Telson, S. Parent counseling. The New Outlook for the Blind, April 1965, 127, 129.

Wilson, E. L. Assessing the readiness of blind persons for vocational placement. The New Outlook for the Blind, February 1974, 57-60.

6 COUNSELING WITH GIFTED STUDENTS: A PLANNED PROGRAM APPROACH

Ronald T. Zaffrann and Nicholas Colangelo

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COUNSELING WITH GIFTED STUDENTS: A PLANNED PROGRAM APPROACH

Ronald T. Zaffrann and Nicholas Colangelo

It is encouraging to note that attitudes, perspectives, and approaches regarding the education of gifted children are changing for the better. In particular, counseling and guidance with gifted and talented students has taken on new dimensions. This chapter is concerned with understanding and programming for the counseling needs of the gifted. Using a step-by-step approach, each phase in program planning for gifted is described, with accompanying examples of intervention strategies appropriate to that phase. The chapter concludes with recommendations for program considerations for "the gifted down the pike."

Over the past several years there has been renewed interest in meeting the educational needs of gifted and talented youngsters. The gifted movement in education has a "patchwork" history: Providing for the needs of gifted has been based more on trends than on solid educational principles. If this current interest in gifted is to be sustained and not to be simply an extension of past trends, then two areas must be addressed:

1. The gifted movement must remove itself from the vestiges of I.Q. scores, standardized test performance, and school grades. The movement needs to encompass a richer and more comprehensive conceptualization of gifted, which must include greater sensitivity to discovering and promoting abilities unique to various cultural groups, exceptional populations (e.g., handicapped), and women.

2. In the past the primary concern of those who work with gifted children has been to meet their learning (classroom) needs. The importance of identifying and meeting the counseling needs of gifted has played a minor (and certainly background) role. Recognition of the importance of self-concept and the relationship between cognitive and affective development makes it imperative that the counseling needs of gifted must become a primary consideration.

In this chapter the authors take the point of view that although gifted students are unique individuals, they possess some common characteristics, the understanding of which can be useful in providing group counseling services. This point of view implies three basic assumptions:

1. Gifted youngsters can be meaningfully grouped according to commonalities in counseling and learning needs.

2. General characteristics of other groups can be useful in understanding individuals within the gifted groups.

3. Knowing the characteristics of a group aids in understanding any individual within that group.

Progress Report:
Where Have We Been? Where Are We Now?

Several years ago Sidney P. Marland, then Commissioner of Education, noted that the most neglected minority in American education was the youngsters identified as gifted (Education of the Gifted and Talented, 1972). Today, this is still very much the case. Administrators still refuse to acknowledge that the gifted need special assistance, or that gifted students are even present in their schools. Teachers cling to timeworn cliches that the gifted will help themselves. Counselors persist in the belief that, if the gifted do need assistance at all, it is probably only with college applications, scholarship information, financial aids, or career choice. Parents know that something is needed but are not sure in which direction to turn.

It is encouraging to note, however, that the picture regarding gifted and talented education is beginning to change. Indications of new provisions for gifted youngsters are present in progress reports, conference proceedings, and project descriptions (Hymes & Bullock, 1975; Johnson, 1976; Plowman & Rice, 1967; Robeck, 1968; Tongue, 1970). Gowan, et al. (1979), Newland (1976), and Piechowski (1979) all describe changing attitudes, perspectives, and approaches regarding the education of gifted children.

In particular, counseling and guidance with gifted and talented students has taken on new dimensions. The need of the gifted for counseling and guidance has been discussed at length in the literature (Abraham, 1976; Colangelo & Zaffrann, 1979a; Gowan, 1960; Gowan & Demos, 1964; Gowan et al., 1969; Pace, 1976; Perrone & Pulvino, 1977; Zaffrann, 1978; Zaffrann & Colangelo, 1977; Ziv, 1976). Studies on self-concept development in gifted youngsters indicate the need for special provisions (Colangelo & Pfleger, 1978; Exum & Colangelo, 1979). Training, service, and research laboratories (Pulvino, et al., 1976b; Rothney & Sanborn, 1968; Sanborn, et al., 1971) have demonstrated what can be done with the gifted.

Most recently, researchers have addressed critical issues in and counselor intervention strategies for counseling with the gifted (Colangelo & Zaffrann, 1979a, 1979b). These areas include creativity (Borgers & Treffinger, 1979; Davis & Rimm, 1979); culturally diverse gifted (Frasier, 1979); handicapped gifted (Gerken, 1979); career development (Fredrickson, 1979; Herr & Watanabe, 1979; Sanborn, 1974); gifted women (Rodenstein & Glickhauf-Hughes, 1979; Wolleat, 1979); working with families (Parker & Colangelo, 1979; Ross, 1964; Sanborn, 1979).

All of this research and study suggest that the picture of counseling and guidance with the gifted is changing in perspective, focus, and depth.

Accelerated and Enriched Gifted

Colangelo and Zaffrann (1979b) presented a perspective which considers acceleration and enrichment not simply as traditional methods of grouping or describing the gifted, but more as conceptualizations of qualitatively different learning styles and learning needs of the gifted. Essentially, acceleration (advanced, fast-paced learning experiences) considers the speed with which gifted youngsters learn and integrate new material. By contrast, enrichment (learning experiences based on depth and perspective) refers to experiences in which students can explore topics in depth and from a number of points of view. In the latter, the student is concerned with generating new ideas and with establishing a relationship with the topic. Perhaps some case studies (adapted from Colangelo and Zaffrann, 1979b) will illustrate our points about accelerated and enriched gifted students.

Case of Joan, an Accelerated Gifted Student

> Joan came from a well-to-do family and attended a prestigious suburban high school. Like her older sister, Joan was expected by her parents and teachers to achieve top grades and honors, especially in language. She consistently earned straight A's throughout her school years, and graduated early from high school after nearly exhausting her school's foreign language curriculum, writing a research report in French, and submitting poetry and a short story for publication.
>
> Joan then attended a university in Europe, where she lived with a family and spent every free moment working to master the French and German languages. Upon her return to this country, she enrolled in a large university to concentrate on these foreign languages and international studies.
>
> Joan talked about her work as if it were something she needed to do--as if she were being pushed from the inside by herself as well as from the outside by parents and teachers. She was aware of "all there was to learn out there," and "couldn't wait" to study more languages and become proficient at them.

Discussion

Joan is a good illustration of an accelerated gifted student because she is interested primarily in mastery and integration of new material. Once she has mastered and integrated certain information and skills, she needs to move on to new areas of challenge, and so on. While "quantity learning" may be involved here, it is critical to note that Joan--like other accelerated gifted students--has an extraordinary ability to assimilate and process information in a sort of "building process." The knowledge that is mastered becomes a base or foundation for mastering other new and more complex information.

Before we discuss how a counselor might try to help Joan, let us examine an illustration of an "enriched" gifted student.

Case of Denny, an Enriched Gifted Student

> Denny grew up on a dairy farm in a small midwestern community. He did superior work in all academic areas throughout his elementary and high school years. In addition, he excelled at football, participated in clubs and organizations, and won several awards, including a scholarship to a major university. Yet, he felt that his most important activity was working with his father on the family farm. Unlike his friends, Denny

enjoyed the daily chores of farm life from an early age, and virtually ran the farm by the time he entered college.

Denny majored in mathematics in college and was able to obtain top grades without studying very hard. This gave him free time to do "more important things"--to audit courses in veterinary science, to serve as a "volunteer vet" and travel with a nearby veterinarian, and to apply for and be awarded a research assistantship with a favorite dairy science professor. By the time he entered his senior year, Denny had changed his major to dairy science, had consumed all available related courses, and was preparing himself to enter veterinary school.

Denny spoke with excitement and pride about his special relationship with his dad, with the veterinarian, and with the professor. He seemed grateful for the opportunities to experience things on his own, and proud about the time and attention he and these significant others had invested in his projects.

Discussion

Denny is a good example of an enriched gifted student because he is interested primarily in forming a relationship with the material or topic. The need is not so much to master the material and then integrate it as to form an emotional relationship with the process of learning. Enriched gifted students like Denny care for the topic or problem as an end in itself. Enrichment as we mean it is not to be confused with simple provision of extra things to do, of extra things that are popular or fun, or of variety. The key to enrichment is relationship and commitment.

Implications for Counselors, Accelerated Gifted

Characteristics	Program Needs	Counseling Implications
· Is exceptionally quick in comprehension · Becomes bored easily if pace is not appropriate · Desires mastery of new material · Pushes self for more; makes demands on self	· Flexible school schedule that allows students to advance on basis of ability, not age. · Advanced/honors classes · Provision for skipping grades · Early graduation to college	· Students may be overly harsh on selves if they "fail" in any area. Counselors must help build realistic self-concepts. · Students may be "overdriven" by teachers and parents. Counselors need to educate others for understanding their limits.

Characteristics

- Sets high goals for self
- Possesses high energy level
- Has high critical thinking ability
- Utilizes intellectual mode of functioning

Program Needs

- Special grouping with other accelerated youngsters
- Programmed learning

Counseling Implications

- Students may be more mature intellectually than socially. Counselors need to help them develop interpersonal relationships.
- Counselors need to help students set goals.
- Counselors should insure that advanced learning materials are available.

Implications for Counselors, Enriched Gifted

Characteristics

- Interacts highly emotionally with environment
- Is given to imagination and fantasy
- Asks many questions about the same topic
- Often is not efficient in tasks
- Is often humorous/witty
- Reflects deeply about issues
- Needs to experience rather than conceptualize
- Forms attachments to people and projects

Program Needs

- Provision for students to pursue projects of interest in great depth
- Provision for student-initiated programs of learning
- Encouragement of school personnel to build long-term working relationships with these students
- Provision for students to spend time with mentors or visit places for firsthand experiences
- Allowance for students to focus on interests rather than on meeting standard curriculum

Counseling Implications

- These students will often be more acutely sensitive than their agemates. Counselors need to help them understand and appreciate their sensitivity.
- These students may be seen as "wasting time" or being silly in their pursuits. Counselors must provide the emotional support to help them face these situations.
- Counselors must initiate a sensitive relationship with students.
- Counselors need to help parents and teachers understand emotional investment of students in what they do.
- Counselors need to provide support and guidance for frustrations of persisting at single task.

Intervention Strategies in Perspective: The Magic of Program Planning

Instead of providing a series of isolated, disjointed services or "strategies" for gifted students, we advocate the use of a planned program in counseling the gifted (Zaffrann & Colangelo, 1977). Although a full discussion of this topic is beyond the scope and purpose of this chapter, we want at least to introduce it briefly here.

Such a program planning effort moves purposefully through essential phases, each with its own goals, focus, and direction. These phases include becoming knowledgeable about philosophy and assumptions concerning gifted people and how they learn; assessing their needs; organizing appropriate goals and objectives; arranging effective delivery systems according to staff, procedures, and resources; evaluating both the process and outcomes; and communicating the results to all involved parties.

I. General Philosophy, Assumptions, Preplanning Issues, and Identification

Focus. People working with the gifted need to start with their philosophy and assumptions about gifted. For example, what are gifted youngsters like? How do they learn? How do they change? What kind of commitment is there for a gifted program from the people who are an integral part of such a program--teachers, administrators, counselors, parents? What kind of assumptions are we making about ourselves as professionals working with gifted youngsters? About these students and their peers? About the kinds of information that must be made available? About the kinds of environments we intend to provide and use as resources?

Included in Table 1 are several critical questions which planners need to address before initiating a gifted program. These questions focus on philosophy and assumptions, key preplanning issues, and methods of identification. Dealing effectively with these preplanning issues can ensure a solid foundation for the actual gifted program.

Benefits. By focusing on philosophy, assumptions, and other issues in this way, we can hope for these benefits:

- A platform is established; people will know where we are coming from regarding this gifted program.

Table 1

Guidance Program Planning Model: Gifted and Talented Programs

I. General Philosophy, Assumptions, Preplanning Issues, and Identification

General Philosophy

- What are gifted people like? (nature of man)
- How do they learn?
- How do they change?
- What do we want our culture/society to look like 20 years from now?
- How will this gifted program fit into that futuristic picture?
- What are your school/community values?
- What kind of gifts/talents do you want to promote?
- Will the predominant flavor of this gifted program be developmental or remedial?

Assumptions

- Can gifted be divided into meaningful groups with homogeneous counseling needs?
- Can general characteristics of these groups be useful in understanding the individual?
- Does knowing these characteristics of a group add knowledge to understanding any individual in that group?

Preplanning Issues

- How will you identify gifted students whose needs are not being met?
- How flexible will you be in meeting the needs you discover?
- Will identified youngsters have a chance to refuse entry into the gifted program?
- Will identified youngsters be expected to enter the gifted program "for the good of our culture/society"?
- Has a commitment to the gifted program been obtained from teachers, counselors, administrators, parents, and students?
- Who will make the decisions about what happens with the students in this program?
- What obstacles do you foresee in starting or maintaining this gifted program?
- What special funds and expertise will be needed?
- What preparation will be needed for teachers/counselors?

Identification

Combination of:

Standardized Measures
  - I.Q. Tests
  - Achievement Tests
  - Interest Inventories
  - Psychological Tests
  - Creativity Tests
  - Values Inventories

Nominations
  - Teachers
  - Parents
  - Peers
  - Self

Products
  - What a student has done at school or outside of school
  - Evaluation by a panel of judges

- Stated philosophy and assumptions really help to give us direction for the program.
- We establish our values and priorities which will inherently be reflected in the program anyway.
- Commitment is established from all necessary participants.

II. Needs Assessment

Focus. After establishing our philosophy and assumptions about gifted education, we should next assess the needs of these youngsters. The WHO and HOW of needs assessment must be established.

Regarding the WHO of needs assessment, we recommend that the counselor serve as coordinator of the system-wide needs assessment, with input coming from students, teachers, administrators, parents, community. Regarding the HOW of needs assessment, input can be obtained through surveys, questionnaires, interviews, and group meetings.

It is important to note that no two systems will likely reveal the same results on the needs assessment. For this reason, merely applying some "canned" program *in toto* to one's school system is likely to be inappropriate. The needs of gifted youngsters differ.

Using the model presented earlier in this chapter we may find that accelerated gifted students need to accumulate, master, and integrate information. Enriched gifted students need to explore, discover, and form a relationship with their learning.

Benefits. These benefits accrue to those who do a solid needs assessment:

- It shows us what youngsters need from us, not just what we want to provide for them or think they need.
- It establishes a solid base for the program, rather than simply the opinions of a few adults.
- It gives a more well-rounded view because input has been obtained from all participants.
- Counselor is the coordinator of the entire system, which is as it should be.

Table 2

Guidance Program Planning Model: Gifted and Talented Programs

II. Needs Assessment

Procedures

- WHO
  - Counselor as coordinator of system-wide needs assessment
  - Input obtained from students, teachers, administrators, parents, community
- HOW
  - Input via surveys, questionnaires, interviews, group meetings
- WHAT
  - Input regarding identification, number of students admitted, cost of program, funding, selection of staff, resources, objectives, evaluation

Example: Focus on Learning Needs

Accelerated Gifted Students

Need for:
Accumulation of knowledge
Mastery of knowledge
Integration of knowledge

Enriched Gifted Students

Need for:
Exploration
Discovery
Relationship with learning

- Based on results of needs assessment, no two systems will likely look the same.
- Needs should be translated into goal areas and goals.

III. Goal Areas and Goals

Focus. Needs assessment data must be translated into categories or areas of needs, which become the general goal areas of the program. For example, common categories include career-vocational needs, educational-academic needs, interpersonal relationship needs, personal development needs, family involvement needs. For each of these general goal areas, a few more specific goals should be developed.

As an example, three clusters of goals from some gifted programs have been (a) excitement, intrinsic motivation, divergent thinking, and accuracy; (b) high achievement, accomplishment, and task completions or progress; (c) affiliations, self-knowledge, and decision-making. The critical issue is that the goals of the program should be developed directly from the needs assessment data for the particular school system.

For example, if an assessment indicated a need for a more intensive family involvement in the gifted program, then this becomes a key goal area on which to focus (see Table 3). From the general goal area, a specific goal can be developed focusing on detailed issues involved in raising a gifted child.

Benefits. Translating needs assessment data into general goals carries these benefits:

- Goals of the program are based on expressed needs.
- Goals are categorized according to appropriate and understandable areas.
- Goals are written so that specific objectives (next step) can be derived from them easily.

IV. Development of Measurable Objectives

Focus. After general goals are listed, it is crucial that they be translated into specific objectives, which become the focal points of the program. This is a critical step. If goals are left general and vague, then it will be impossible to conduct a comprehensive, effective, and valid evaluation later. If any step in gifted education programs is done sloppily or skipped altogether, it is usually this phase of writing good objectives.

Table 3

Guidance Program Planning Model: Gifted and Talented Programs

III. Goal Areas and Goals

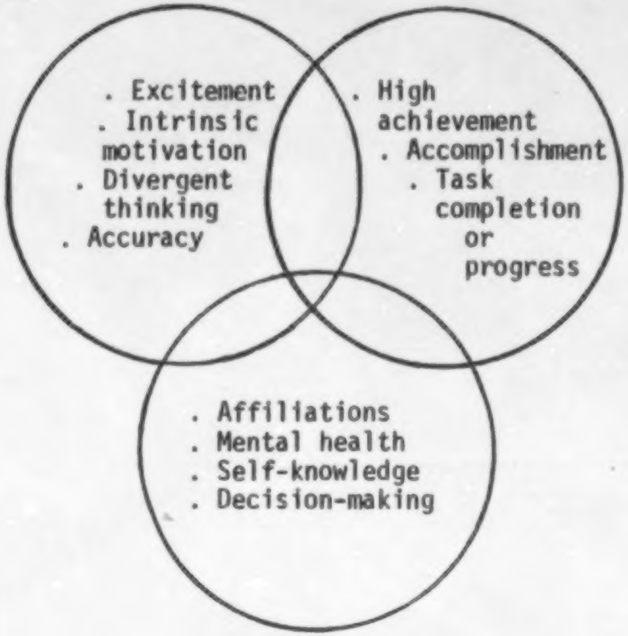
Procedures

- Translate needs assessment information into general goal areas.
- For each goal area, develop two or three goals.

Example 1: Goal Areas

- Career-vocational development
- Educational/academic development
- Interpersonal relationships
- Personal development
- Family involvement

Example 2: Goal Areas


. Excitement
. Intrinsic motivation
. Divergent thinking
. Accuracy
. High achievement
. Accomplishment
. Task completion or progress
. Affiliations
. Mental health
. Self-knowledge
. Decision-making

- To develop awareness within the individual family of problems, interests, and issues which may develop when raising a gifted and talented child.
- To develop career exploration activities whereby gifted youngsters are exposed to various opportunities to develop their talents and interests.

Good objectives need these six components: (1) HOW MUCH (amount of change, level to be attained); (2) HOW MEASURED (assessment techniques); (3) WHO (will perform the activity); (4) DOES WHAT (to be known or performed); (5) WHEN (specific time); (6) UNDER WHAT CONDITIONS (Perrone, 1979).

To continue our example on family involvement, two objectives have been developed to reach the previously listed goal. These objectives focus on family and social dynamics with gifted children.

Table 4a outlines the components of objectives and delivery systems and provides an example of a goal area (family involvement), a narrower goal, and two specific objectives relating to involving the family in the guidance program planning model.

In Table 4b, the example is taken one step further. In addition to general goal area, goal, and two objectives, we now have added activities, procedures, staff responsibility, needed resources, time table, and level. Following this procedure, educational activities in a gifted program are logical extensions of assessment and goals.

Benefits. By translating general goals into specific objectives, the gifted program realizes these benefits:

- Program has measurable objectives based on general goals.
- Objectives are written by coordinator and participants.
- Activities, procedures, and staff involvement are outlined.

V. Delivery System

Focus. After specific objectives are developed, the focus turns to the delivery system or process of intervention. Too often, this is the only step with which educators are really concerned. It is almost as if a storage room full of kits, tricks, films, resource packages, cards, games, and simulations can take the place of a purposefully planned program. This simplistic notion must be abandoned if we are to assist bright, able youth effectively.

The delivery system is divided into the areas of staff, procedures, and resources. Under staff we consider counselors, administrators, teachers, parents, and peers. Depending upon the outcomes desired in the gifted program plan, staff members will differ. For example, counselors could perform

Table 4a

Guidance Program Planning Model: Gifted and Talented Programs

IV. Development of Measurable Objectives

Six components of objectives and delivery systems

. HOW MUCH (amount of change, level to be attained)
. HOW MEASURED (assessment techniques)

. WHO (will perform the activity)
. DOES WHAT (to be known or performed)
. WHEN (specific time)
. UNDER WHAT CONDITIONS

Target Audiences

. Gifted students
. Staff

Example

Goal Area: Family Involvement

Goal: To develop awareness within the individual family of problems, interests, and issues which may develop when raising a gifted and talented child.

Objectives:

(1) On family dynamics involving the gifted and talented child: understanding how to relate to the gifted and talented child in the home; use of rewards and discipline; understanding the uniqueness of the gifted and talented personal needs; activities involving the entire family unit.

(2) On social aspects of the gifted and talented child: understanding how differences in social development may accelerate in relation to giftedness.

Table 4b

Guidance Program Planning Model: Gifted and Talented Programs

IV. Development of Measurable Objectives

GOAL AREA: Family involvement

GOAL: To develop awareness within the individual family of problems, interests, and issues which may develop when raising a gifted and talented child

SPECIFIC OBJECTIVE: *(1) On family dynamics involving the gifted and talented child: understanding how to relate to the gifted and talented child in the home; use of rewards and discipline; understanding the uniqueness of the gifted and talented personal needs; activities involving the entire family unit.*

(2) On social aspects of the gifted and talented child: understanding how differences in social development may accelerate in relation to giftedness.

CRITERIA FOR EVALUATION: *Parental feedback to counselor and teacher of the gifted through conferences, parent groups, group discussion, and questionnaire at the end of the year.*

ACTIVITY OR STRATEGY	PROCEDURES	STAFF RESPONSIBILITY	RESOURCES: MATERIAL PEOPLE	TIME TABLE	LEVEL
Parent discussion; *Mini-unit on child development*	*Guidance* *Working with parent groups*	*School counselor*	*S.T.E.P. Kit*	*September to November* *Evening meetings*	*Parents of gifted children, Grades 1-4*
Classroom unit on physiology and development to complement guidance mini-unit	*Instruction* *Take-home projects for children to work on with their parents;* *Presentation to school or community.*	*Teacher of gifted and talented*	*Life-size physiology model with pull-out parts*	*September to November* *Classroom meetings*	*Gifted children, Grades 1-4*

at least these counselor functions: counseling, consulting, coordinating. Specific techniques or approaches for each function would correspond to those listed in Tables 4a and 4b. Other staff members would also perform certain functions depending upon the established objectives.

In addition to staff, the program process also includes procedures and resources. Procedures have been subdivided into instructional, administrative, counseling and guidance, family involvement, and community involvement. Examples are listed here and have been suggested elsewhere (Colangelo & Zaffrann, 1975, 1979a, 1979b; Zaffrann, 1978; Zaffrann & Colangelo, 1977).

Resources, which could include many facets in a gifted program, are subdivided into printed resources, people and agency resources, and audiovisual materials.

To continue with our family involvement example, counselors could use the Systematic Training for Effective Parenting (STEP) kit as an introduction to exposing families with a gifted youngster to communication patterns and sibling dynamics. Parent discussion groups could focus on issues such as sibling rivalry, school concerns, peer relations, emotional needs of gifted children, perceived adequacy of parents in raising a gifted child, and parental needs for assistance in better understanding the cognitive and affective needs of their gifted child.

Benefits. If the program process or delivery system (that is, the staff, procedures, and resources) is organized in this way, several benefits should occur:

- Counselor role and function are better defined.
- Teachers, counselors, parents, and peers become involved.
- Procedures are organized into areas most likely to be used with gifted students.
- Resources are catalogued and thus should be more obtainable.

VI. Evaluation

Focus. An evaluation component is necessary and vital to the life and strength of a gifted program. In practice, however, evaluation may consist only of feedback sheets hastily contrived to satisfy funding agencies.

Table 5

Guidance Program Planning Model: Gifted and Talented Programs

V. Delivery System

	Staff				
	Counselors	Administrators	Teachers	Parents	Peers
Examples	Counseling · 1-to-1 · group · developmental outlook · counseling model for understanding gifted · infusing guidance into curriculum · special groups handicapped culturally diverse families Consulting · target groups teachers administrators parents community state organizations state legislators · interventions in-service · legislation Coordinating · program development and planning · program evaluation and research evaluation case studies action research follow-up program continuity	· allowances for special provisions · provision of necessary staff and resources to implement an effective program · definition of philosophy and commitment of the school to gifted education · provision to school personnel and community of accurate information on the goals and purposes of the gifted program	· classroom guidance · individualized programs for the gifted · evaluation of pupil progress · development of appropriate learning materials and experiences for gifted · diverse methods of instruction · support of risk-taking and curiosity in all areas	· parent groups · educational activities at home	· peer guidance

Procedures				
Instructional	Administrative	Counseling and Guidance	Family Involvement	Community Involvement
. IGE . independent study	. individual and group provisions	. Developing Understanding of Self and Others (DUSO) I and II Kits . Toward Affective Development (TAD) Kit . home-made activities	. parent groups . Systematic Training for Effective Parenting (STEP)	. shadowing . internships . mentors
See Pulvino, Colangelo, & Zaffrann, 1976b	See Sanborn, Pulvino, Wunderlin, 1971; Zaffrann, 1978	See Colangelo & Zaffrann, 1975	See Colangelo & Zaffrann, 1975	

Resources		
Printed	People/Agencies	A-V Materials
. for comprehensive list of printed resources, see Colangelo and Zaffrann, 1979b	. home-made directory	. GA . AGS . Argus . filmstrips . tapes . packaged kits

Resources Worksheet

Resources Needed	Publisher Address	Unit Cost

Evaluation is essential for determining the effectiveness of both outcomes and process of the program. The evaluation section is divided into the areas of WHAT, WHO, WHY, and HOW. (For further discussion on these areas, see Pulvino, Colangelo, & Zaffrann, 1976a.)

The WHAT of evaluation is related to the objectives listed in Phase IV (regarding outcomes) and to the process described in Phase V (regarding process). The WHO of evaluation depends on whether an internal or external team is used, and who is asked to participate. Ideally, all participants in the needs assessment phase should participate in the evaluation phase. This phase is related to the WHY of evaluation, which dictates that the purposes of the evaluation be spelled out clearly. The HOW of evaluation is usually the most difficult aspect of program planning. Crabbs and Crabbs (1977) have listed several methods of evaluation (see Table 5).

Regarding the family involvement example, feedback from parents and their gifted child, along with observations from counselors and teachers, could focus on the effectiveness of activities and the general delivery system used in the gifted program. Such feedback and observations could be used to examine whether or not parents did in fact increase their understanding of the various issues listed under objectives for this goal, e.g., uniqueness of the gifted child or differences in social development of the gifted child.

Benefits. Evaluation of a gifted program produces several benefits:

- The evaluation focuses on outcomes regarding program objectives. That is, it reveals whether we did what we said we were going to do for our gifted youngsters.
- The evaluation focuses on process. That is, it shows clearly how effective the staff, procedures, and resources were in accomplishing what we did for these youngsters.
- The evaluation can be conducted in a number of different ways, using different personnel, depending on the purpose.
- Evaluation makes the program accountable and defensible.
- The evaluation component causes all the efforts to result in a gifted program, not just a roster of separate strategies.

Table 6

Guidance Program Planning Model: Gifted and Talented Programs

VI. Evaluation

Evaluation of Product Outcome

Refer to: Section IV, Development of Measurable Objectives

Focus question: How will we know if we accomplished through this gifted program what we wanted to accomplish?

← WHAT →

WHO

- internal team
- external team

WHY

- define purposes of evaluation (see Pulvino, Colangelo, & Zaffrann, 1976a)

HOW*

- satisfaction surveys
- experimental designs
- status studies
- tabulation studies
- follow-up
- case studies
- achievement of goals studies
- time-cost analysis
- self-evaluation

TARGET AUDIENCE

- gifted students
- teachers of gifted
- parents of gifted
- administrators

Evaluation of Process

Refer to: Section V, Delivery System

Focus question: How will we know if the process was effective?

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*From Crabbs, S. K., & Crabbs, M. A. Accountability: Who does what to whom, when, where, and how? The School Counselor, November 1977, pp. 104-109.

VII. Communication of Results

Focus. In this phase of program planning, results of evaluation are communicated to all participants who have been involved since the initial phase of philosophy and assumptions, and needs assessment.

Benefits. Benefits from communicating results to participants include:

- Good information and publicity to original participants regarding effectiveness of the program.
- Feedback to the system regarding needs, objectives, process.
- Closure on a program, not simply individual activities or techniques.

Benefits of a Program Planning Approach

Well-done program planning is the ultimate "practical intervention strategy." With it comes a number of invaluable benefits:

- Rather than being a "waste of precious time," program planning actually saves time in the long run because it creates a crisp, clear map of where we are going with our ideas and procedures about gifted education.
- Program planning makes our actions accountable and defensible. These may be overworked educational terms, but it is becoming increasingly evident that programs which do not grow from a defensible foundation simply do not survive.
- Program planning includes everyone. The onus is not on counselors or school alone; many other staff take responsibility for program design, delivery, and evaluation.

Where Should We Be Going? The Gifted Down the Pike

Several areas of programming for gifted need to be considered in planning for the future. Consideration of these areas can lead to a stable programming pattern for gifted based on sound educational principles.

Need for Continuous Program Planning at All Levels of Working with Gifted

There is a need in gifted education for a stable program planning approach. With such an approach comes continuity, development, and long-lasting provisions. We need to remove gifted education from "one-shot

Table 7

Guidance Program Planning Model: Gifted and Talented Programs

VII. Communication of Results

- Results communicated to all participants in needs assessment (Phase II).
- Results fed back into system to reconsider needs assessment (Phase II), goals (Phase III), objectives (Phase IV), delivery system (Phase V).
- Results communicated via written report, group meetings, brief notes, releases.

deals," "bandwagons," and almost total reliance on state or federal funding. It has been our experience with many school districts that enthusiasm in providing for gifted is highly correlated with funds received.

Need to Generalize Gifted Programming Benefits to *All* Youngsters

The end purpose of programming for gifted students is to provide them with educational opportunities appropriate to their abilities, not to remove them from other populations of youngsters. Many of the provisions that would benefit gifted would also benefit other students. Gifted education will be viewed more positively if it is seen as leading toward better education for all students.

Need to Focus on *Special* Populations of Gifted Youngsters

The gifted movement has considerable progress to make in recognizing and programming for gifted culturally diverse, females, and handicapped students. The challenge to meet these needs entails a more comprehensive conceptualization of gifted, more flexibility in programming, and more commitment to the uniqueness of gifted youngsters.

Need to Focus on Gifted Adults

Most efforts toward improving opportunities for gifted have focused on school-age youngsters. However, schools (and perhaps more so, industry and government) need to consider how to provide special opportunities for gifted adults. Good program planning can provide for the needs of high ability individuals in terms of "lifetime" planning.

Summary

In order to provide meaningful opportunities for gifted we need first to identify general characteristics of gifted. The accelerated/enriched model of gifted provides direction for program planning.

The key to the future of gifted education is program planning. By this we mean developing short-term and long-term goals based on sound educational principles that will transcend "trends" and "bandwagons."

This article has provided some specific guides for program planning that would be appropriate to gifted individuals at all levels.

REFERENCES

A mother and father of a gifted child find the helping professions helpless. Gifted Child Quarterly, Summer 1974, 18(2), 110-111. ERIC Journal EJ 109 351.

Abraham, W. Counseling the gifted. Focus on Guidance, 1976, 9(1), 1-12.

Baker, H. J. Biographical sagas of willpower. New York: Vantage Press, 1970.

Barron, F. Creative person and creative process. New York: Holt, 1969.

Borgers, S., & Treffinger, D. Creative talent: Implications for counselors. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Bragg, B. The human potential of human potential: Art and the deaf. American Annals of the Deaf, 1972, 17, 508-511.

Bruch, C. B. A rationale for identification and development of the disadvantaged gifted. TAG Gifted Children's Newsletter, 1979, 11, 21-28.

Casserly, P. L. Helping able young women take math and science seriously in school. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Colangelo, N., & Pfleger, L. R. Academic self-concept of gifted high school students. Roeper Review: A Journal of Gifted Child Education, 1978, 1(1), 10-11.

Colangelo, N., & Zaffrann, R. T. Counseling the gifted student. Madison, WI: Research and Guidance Laboratory for Superior Students, University of Wisconsin, 1975. ERIC Document ED 123 865. Microfiche edition.

Colangelo, N., & Zaffrann, R. T. Special issues in counseling the gifted. Counseling and Human Development, 1979a, 11(5), 1-12.

Colangelo, N., & Zaffrann, R. T. (Eds.). New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979b.

Crabbs, S. K., & Crabbs, M. A. Accountability: Who does what to whom, when, where, and how? The School Counselor, November 1977, 104-109.

Davis, G. A., Peterson, J. M., & Farley, F. H. Attitudes, motivation, sensation seeking, and belief in ESP as predictors of real creative behavior. Journal of Creative Behavior, 1973, 7, 31-39.

Davis, G., & Rimm, R. Identification and counseling of the creatively gifted. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Education of the gifted and talented. Report to the Congress of the United States by the U.S. Commissioner of Education. Washington, D.C.: U.S. Government Printing Office, 1972.

Elkind, J. The gifted child with learning disabilities. Gifted Child Quarterly, 1973, 17(2), 96-97.

Exum, H. A., & Colangelo, N. Enhancing self-concept with gifted black students. Roeper Review: A Journal on Gifted Child Education, 1979, 1(3), 5-6.

Frasier, M. M. Counseling the culturally diverse gifted. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Fredrickson, R. Career development and the gifted. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Gallagher, J. J. Teaching the gifted child (2nd ed.). Boston: Allyn & Bacon, 1975.

Gerken, K. C. An unseen minority--handicapped individuals who are gifted and talented. In N. Colangelo & R. T. Zaffrann (eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Goertzel, V., & Goertzel, M. G. Cradles of eminence. Boston: Little, Brown, & Co., 1962.

Gowan, J. C. The organization of guidance for the able. Personnel and Guidance Journal, 1960, 39(4), 275-279.

Gowan, J. C., & Demos, G. D. The education and guidance of the ablest. Springfield, IL: Charles C. Thomas, 1964.

Gowan, J. C., Khatena, J., & Torrance, E. P. Educating the ablest: A book of readings on the education of gifted children (2nd ed.). Itasca, IL: F. E. Peacock Publishers, Inc., 1979.

Gowan, J. C., Morrison, C., Groth, N. J., Pasternack, M., & Drake, M. New aspects in guiding the gifted in demonstration classes. Gifted Child Quarterly, 1969, 13(2), 103-112. ERIC Journal EJ 007 725.

Guilford, J. P. The nature of human intelligence. New York: McGraw-Hill, 1967.

Herr, E., & Watanabe, A. Counseling the gifted about career development. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Hymes, R. M., & Bullock, F. O. Alternative schools answer to the gifted child's boredom. Gifted Child Quarterly, 1975, 19(4), 340-345. ERIC Journal EJ 131 023.

Johnson, B. (Ed.). New directions for gifted education (Brief No. 3, National/State Leadership Training Institute on the Gifted and Talented). Los Angeles, CA: Report on Biocentennial Midyear Leadership Training Institute, Kansas City, January 26-27, 1976. ERIC Document ED 131 620. Microfiche edition.

Kaplan, S., & Williams, M. J. Confrontation counseling: A new dimension in group counseling. American Journal of Orthopsychiatry, January 1972, 42(1), 114-118. ERIC Journal EJ 099 474.

Morishima, A. Another Van Gogh of Japan: The superior artwork of a retarded boy. Exceptional Children, 1974, 41, 92-96.

Newland, T. E. The gifted in socio-educational perspective. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1976.

Pace, C. Counseling the academically bright. School Guidance Worker, 1976, 32(1), 10-11. ERIC Journal EJ 144 410.

Parker, M., & Colangelo, N. An assessment of values of gifted students and their parents. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Perrone, P. Unpublished manuscript. Madison, WI: University of Wisconsin, 1979.

Perrone, P.A., & Pulvino, C. J. New directions in the guidance of the gifted and talented. Gifted Child Quarterly, 1977, 20(7), 326-335.

Piechowski, M. M. Developmental potential. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Plowman, P. D., & Rice, J. P. Demonstration of differential programming in enrichment, acceleration, counseling and special classes for gifted pupils in grades 1-9 (Final report). Sacramento, CA: California State Department of Education, March, 1967. ERIC Document ED 019 763. Microfiche edition.

Pulvino, C., Colangelo, N., & Zaffrann, R. T. Departmental evaluations: Threats and solutions. Journal of Counseling Services, 1976a, 1(2), 20-28.

Pulvino, C. J., Colangelo, N., & Zaffrann, R. Laboratory counseling programs: Counseling and program development for gifted. Madison, WI: Research and Guidance Lab for Superior Students, University of Wisconsin, 1976b. ERIC Document ED 131 614. Microfiche edition.

Riessman, R. The culturally deprived gifted. New York: Harper and Row, 1962.

Robeck, M. C. California Project Talent: Acceleration programs for intellectually gifted pupils. Sacramento, CA: California State Department of Education, 1968. ERIC Document ED 034 353. Microfiche edition.

Rodenstein, J., & Glickhauf-Hughes, C. Career and life-style determinants of gifted women. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Ross, A. O. The exceptional child in the family. New York: Grune & Stratton, 1964.

Rothney, J. W. M., & Sanborn, M. P. Promising practices in the education of superior students: A demonstration program. Madison, WI: University of Wisconsin, 1968. ERIC Document ED 028 547. Microfiche edition.

Sanborn, M. P. Career development: Problems of gifted and talented students. In K. Hoyt & J. Hebeler (Eds.), Career education for gifted and talented students. Salt Lake City, UT: Olympus, 1974.

Sanborn, M. P. Working with parents. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Sanborn, M. P., Pulvino, C. P., & Wunderlin, R. Research reports: Superior students in Wisconsin high schools. Madison, WI: Research and Guidance Laboratory for Superior Students, University of Wisconsin, 1971. ERIC Document ED 083 772. Microfiche edition.

Schauer, G. H. Emotional disturbance and giftedness. Gifted Child Quarterly, 1976, 20(4), 470-476.

Sharp, L. W. The effects of a creative thinking skills program on intermediate grade educationally handicapped children. The Journal of Creative Behavior, 1976, 10(2), 138-145.

Stanley, J. C. Rationale of the Study of Mathematically Precocious Youth (SMPY) during its first five years of promoting educational acceleration. In J. C. Stanley, W. C. George, & C. H. Solano (Eds.), The gifted and the creative. Baltimore, MD: The Johns Hopkins University Press, 1977.

The Gifted, Exceptional Children Bibliography Series. Arlington, VA: Council for Exceptional Children, Information Center on Exceptional Children, 1969. ERIC Document ED 036 037. Microfiche edition.

Tongue, C. (Ed.). The proceedings of the sessions on gifted and talented children (21st Special Education Conference, Charlotte, North Carolina, November 20-22, 1969). Raleigh, NC: North Carolina State Department of Public Instruction, April, 1970. ERIC Document ED 038 824. Microfiche edition.

Torrance, E. P. Creative positives of disadvantaged children and youth. Gifted Child Quarterly, 1969, 13(1), 71-81.

Torrance, E. P. Guiding creative talent. NJ: Prentice-Hall, 1962.

Wolleat, P. Guiding the career development of gifted females. In N. Colangelo & R. T. Zaffrann (Eds.), New voices in counseling the gifted. Dubuque, IA: Kendall/Hunt, 1979.

Zaffrann, R. T. Gifted and talented students: Implications for school counselors. Roeper Review: A Journal on Gifted Education, 1978, 1(2), 9-13.

Zaffrann, R. T., & Colangelo, N. Counseling with gifted and talented students. Gifted Child Quarterly, 1977, 20(7), 305-321.

Ziv, A. Guidance for the gifted. School Guidance Worker, 1976, 32(1), 45-47. ERIC Journal EJ 144 417.

7 SEXUAL FULFILLMENT FOR THE HANDICAPPED

Edith P. Schneider and Rachael F. Schneider

The founder of Cerebral Palsy of Greater Boston nearly 30 years ago, Edith Povar Schneider, born with C/P, is now its Program Director. She continues today her drive to improve life for the handicapped. She has initiated many "firsts." These include trips for the handicapped outside of the United States and the establishment of many summer camps. She has received national recognition for her work, and helped found the United Cerebral Palsy Association. The scholarships she has won have enabled her to attend classes at Boston College, Boston University, and Harvard. Mrs. Schneider has written several articles for national magazines and serves on the Boards of a number of human service agencies. She has done extensive sexual counseling with the multiply handicapped, acted as an advocate, and lectured extensively. She has earned a highly respected place in the community because of her work with the handicapped. In addition to a successful professional career, Mrs. Schneider has a rewarding personal life in her marriage to a practicing attorney, with a beautiful and talented daughter, now 21 years of age, who is co-author of the article.

Rachael F. Schneider graduated from the University of Pennsylvania where she received her B.S. in Occupational Therapy. She has worked for the past eight years with cerebral palsied adolescents and adults, as well as with multiply-handicapped children. Recently she has begun to offer counseling services to children of handicapped parents. On the personal side, she is a talented musician and an artist.

SEXUAL FULFILLMENT FOR THE HANDICAPPED

Edith P. Schneider and Rachael F. Schneider

Due to their exposure to familial and societal fears and misconceptions as well as their own internalized insecurities, handicapped children often lack a confident self-image and necessary social skills. As adults they have difficulty engaging in intimate, sexual relationships, yet most need such relationships to attain true fulfillment in life. Sexual counseling which deals with such issues is vital; however, few nonhandicapped counselors feel qualified to offer these services. Through exploration of counselors' own sexual values and attitudes toward the handicapped, as well as sensitive consideration of disabled individuals' needs and realistic assessment of their capabilities, sexual counseling of the handicapped becomes possible and effective.

Never before have the needs of the handicapped been understood more fully and dealt with more effectively. Gradually changing societal attitudes have allowed the disabled to assert themselves as productive, independent individuals. The removal of architectural barriers has greatly facilitated their entrance into the work force and participation in social activities, and has increased their exposure to nonhandicapped individuals. In spite of these changes, however, both nonhandicapped and handicapped people still maintain deeply internalized misconceptions with regard to the disabled individual's sexuality and ability to engage in intimate relationships. Because such relationships are essential to self-fulfillment, health professionals must begin to acknowledge these special needs and learn to provide effective and sensitive sexual counseling for the handicapped.

During the past 15 years I have been providing sexual counseling to handicapped adolescents and adults, but my awareness of this need has existed for a lifetime. I was born with cerebral palsy and am the oldest daughter in a family of five. Sexuality was all around me during my childhood. I saw Gable and Garbo on the silver screen, heard advertisements for "perfume of passion," and watched my younger sisters apply makeup in preparation for their Saturday night dates. I was very much aware of my own desire to date, marry, and have children. I also vividly remember my frustrations with the limited social arenas available, continuing parental dissuasion regarding my social life, and, more significantly, my fears of rejection when I socialized with nonhandicapped boys. After all, who would want to date me with my slurred speech and contorted body postures?

Even my limited social activities, however, were more than what most moderately- to severely-involved cerebral palsied adolescents experienced. In retrospect, I believe that my social experience, coupled with the encouragement toward independence which my parents provided, gave me the courage to marry. Several years later my husband, who was also born with cerebral palsy, and I chose to have a child. Ironically, as my husband and I began our independent careers and created a family of our own, we encountered tremendous disapproval from both of our parents. During the fifties the notion of two handicapped adults marrying was unheard of; needless to say, the idea of having a child was even more shocking.

Prior to ten years ago most multiply-handicapped adolescents and adults, with disabilities including cerebral palsy, spina bifida, blindness, spinal cord injury, and others, lived a life of social isolation under the overprotective roofs of their families or in the deprivational environments of state institutions. This denial of social and sexual experiences dramatically alters the vital psychosocial/sexual development of handicapped individuals, and the further effects on their personal, social and sexual adjustments are overwhelming.

The normal psychosocial/sexual development of nonhandicapped individuals leads to the understanding that they are desirable sexual beings with the capacity to fulfill their sexual drives and their needs for intimacy. During childhood and adolescence, they are exposed to various adult role models and social cues. Children internalize these images and then actively experiment with them through imaginary play and social activities. A process of acceptance and rejection of gender-appropriate

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behaviors occurs as children are offered vast opportunities to formulate their sexual identity.

Joining social clubs, watching television, playing games, exploring their bodies, and experiencing role model approval all combine to form children's sexual identity. Most important, children are active participants throughout the process and receive constant reinforcement for their efforts (Bidgood, 1974). As children near the end of adolescence, they begin to acquire a mature sexual identity. Such an identity includes the following perceptions and skills:

Body image - a mental and emotional picture of the sexual desirability of one's body and face.

Physiological responses - a realistic knowledge of the components of sexual activity including bodily responses (such as erection or vaginal secretion), sexual fantasy, or physical contact with desired partner.

Psychological adjustment - the ability to engage and share in sexual and intimate relationships as well as to deal maturely with the problems and consequences of such relationships.

Social skills - the acquisition of humor, sensitivity, self-confidence, mobility, and independent thought, all of which enable one to communicate and engage in relationships with one's partner or with groups.

Self-concept - a self-imposed judgment of one's values, intellectual and aesthetic capabilities, and social skills. (Rehab Brief, 1978)

Admittedly, few of us possess a realistic body image or are always able to manage our intimate relationships, but the level of understanding and experience of a nonhandicapped adult is drastically different from that of the adult who is moderately to severely handicapped from birth, or even the mildly disabled individual with a highly supportive family (Bidgood, 1974). Not only must the disabled adult deal with an inadequate sexual identity, he/she must also struggle to overcome societal misconceptions and an overprotective family.

From the moment of birth, the handicapped child is introduced into a world of frustration, denial, overprotection, and guilt. These feelings perpetuate what is already highly inadequate psychosocial/sexual development. The birth of a handicapped child also introduces a world of frustration and guilt to the parents, for a vast array of protective behaviors materializes, albeit often unconsciously (Geiger & Knight, 1975).

In the earliest stages a handicapped infant is generally viewed as fragile. Parents, family members, and friends are afraid to hold or cuddle the infant and thereby unknowingly deny the baby physical contact; yet such contact is essential in the infant's discovery about his/her body in relationship to self as well as others. Body contact is further restricted if the young child is physically unable to explore his/her own body. The lack of genital contact and familiarity with one's own body provides a very weak foundation for the child's body image, which is the first aspect of sexual identity. The child's poor body image is reinforced as his/her major preoccupation becomes watching love entanglements of glittering stars on television and movie screens. Both of these media, as well as sexually explicit advertisements, emphasize the importance of beautiful mobile bodies for successful love affairs, and as a result, the handicapped child comes to see his/her body as ugly and undesirable.

Other aspects of sexual identity also fail to mature. In normal psychosocial/sexual development, children discover gender-appropriate behavior and social skills through play, observation, and reinforcement. However, the most important element in children's development is their active role in this process which allows them to acquire a repertoire of socially-appropriate behaviors. A major difference between the socialization of the handicapped and the nonhandicapped child is the level of this participation. The moderately to severely handicapped child is usually a passive participant in his/her psychosocial/sexual development (Bidgood, 1974). Role models as well as expectations are presented to the child, yet opportunities to actively try out and accept or reject such behaviors prove difficult. For instance, a familiar game such as "doctor" or "house" presents tremendous barriers for the quadriplegic cerebral palsied child who may be dependent upon a wheelchair and unable to explore the environment independently or even engage in conversation. Fantasies and thoughts remain untouched in the child's head. Even for the child who can communicate understandably and requires only minimal assistance to play, available playmates are often lacking. A self-perpetuating cycle occurs as the child grows older and encounters repeatedly the same frustrations, passive observations, and disappointments, and thereby fails to acquire vital social skills. Yet most important, the child still maintains vivid fantasies of marriage, popularity, and success.

The child's development also becomes limited by familial failure to nurture sexual exploration. In using the term sexual exploration, I am referring not only to sexual activity but also to the whole range of intimacies, emotional attachments, flirting, dating, and parties. Such experiences are vital to growing adolescents, but handicapped adolescents are denied these experiences because of their physical handicap and the emotional barriers it creates for them, their families, and the other people they encounter.

Parental failure to encourage sexual exploration can be traced to overprotection (Cole, 1976). Protection is a natural desire in all parents, yet it becomes justifiably intensified in parents of handicapped children. From the beginning, the child is regarded as fragile and therefore invokes an array of protective behaviors. Encouraging independence is far easier said than done in view of the fact that parents must watch their child day after day struggle with failure in order to come closer to achieving a simple goal. I cannot count the number of times I have seen a well-meaning parent grab the spoon from a child just as the child was about to reach his/her mouth after a five-minute struggle. Nor can I count the number of times I have seen a parent verbalize a child's need before the child with speech difficulty had finished the first three words. Parents often justify such actions in the belief that the child is at enough of a disadvantage in life that exposure to more failures or embarrassment should be avoided. Another contributing factor is the parents' own subconscious desire to protect themselves from seeing their child's struggle with failures because that struggle reinforces their own feelings of guilt. However, such protection, whatever the cause, becomes detrimental to children's needs when it stifles their acquisition of an identity unique to themselves.

Overprotection often increases when the child enters adolescence. At this time handicapped boys and girls become concretely aware of their sexuality through the onset of menstruation and/or growth of pubic hair. Adolescents naturally manifest behaviors and feelings such as idolizing movie and rock stars, having crushes on schoolmates, and becoming increasingly aware of their physical appearance. In spite of these obvious signs, parents often choose to ignore their child's growing sexuality. This denial, leading to active prevention of opportunities which allow discovery through learning, greatly inhibits the child's struggle to achieve sexual identity.

One reason for this continual overprotection is the inability of parents to see their son or daughter as a maturing individual (Bidgood, 1974). It is most often the parents who provide for daily caretaking needs so that in spite of any attempts at emotional independence, the adolescent ultimately remains a dependent person (Geiger, 1975). This dependence allows the parents to continue to regard their obviously growing adolescent as a vulnerable child. As a result of this perception the parents deny and therefore disregard the existence of the adolescent's active sex drive.

Another common reason for overprotection is the parents' denial of their son's/daughter's emotional maturity. The parents may be right in assuming that their child is not yet adult emotionally, but their concern and overprotection create even greater helplessness and immaturity. For example, rarely are handicapped children or teenagers given the opportunity to make decisions, formulate opinions, or choose between right and wrong. As a result their efforts at problem-solving are often impulsive and easily influenced by others, their moral judgment often inconsistent and unstable. The parents view their child as being extremely vulnerable within any relationship, not to mention one involving sex. In general, the parents believe that their teenagers will be unable to manage the emotional intensities, decisions, and rejections of such intimate relationships, and ultimately fear pregnancy with all of its obvious implications.

Finally, even parents who are able to accept that their son/daughter can engage successfully in an emotional relationship may fail to encourage it due to a lack of education as to available sexual options. Hence in many respects, parents are themselves handicapped as they maintain these deeply internalized fears for their child which only foster dependence and emotional and sexual immaturity (Geiger & Knight, 1975). Their double bind is clearly evident, as what they most want for their child is the highest level of self-sufficiency possible and, ultimately, marriage.

The final factor which perpetuates the limited sexual development of the disabled individual is societal perception. Since the beginning of humankind, individuals with handicaps, whether they be physical, mental, or emotional, have been hidden from the eyes of society. Such limited exposure has allowed the formation of deeply internalized attitudes toward the handicapped. The most prevalent of these is the belief that the handicapped individual is either asexual or hypersexual (Schaffer, 1964). Such false beliefs probably stem from the emphasis in our society on physical appearance. As physically handicapped individuals are undeniably disfigured in some form, many people regard them as undesirable sex objects; thus, it is difficult to visualize their involvement in, or desire for, a sexual relationship. Imagine, if you will, your own reaction if you were to engage in sex with an upper extremity amputee or a quadriplegic athetoid cerebral palsied. The fact is that we as health professionals are also people with deeply internalized feelings towards the disabled.

Such attitudes lead to the belief that the disabled either have no interest in sex or that those who are institutionalized are dangerously hypersexual. Other misinformed individuals may admit to the existence of normal sex drives but, because handicapped individuals would never have the opportunity to fulfill these desires, view discussion as futile and therefore to be avoided (Schneider, 1976).

These societal beliefs have created a vastly limited social arena for the disabled. In spite of recent legislation mandating removal of architectural barriers, access to bars, theatres, and restaurants still proves extremely difficult for many handicapped individuals. The simple delight of dating becomes a complicated, highly-pressured event. If the disabled individual is able to overcome initial fear of rejection and ask out another disabled adult (for it is rare to ask a nonhandicapped adult), the problems are only just beginning.

The choice of activity becomes determined by availability of transportation as well as accessibility of the social facility. Wheeling two wheelchairs into a small, intimate restaurant, for example, creates an extremely awkward situation. Tables must be moved, waiters and waitresses become self-conscious, and invariably other customers leave the restaurant, as they become uncomfortable watching the disabled couple struggling to eat. The necessity of chaperones must also be considered if independent transportation, mobility, and feeding are impossible. Thus, for the handicapped couple the joy of privacy is lost. Further, finding willing chaperones is a task in itself. Few handicapped persons want a member of their well-meaning yet overprotective family to participate in an evening out. Hence, even the most simplistic stages of experimenting with sexuality become tension-filled for the handicapped, which greatly reinforces their differences and nonacceptance within the mainstream of society.

As can be vividly seen, the handicapped from birth face multiple sexual and emotional problems. Aside from dealing with their poor self-image and deeply ingrained insecurities, they are also confronted with familial overprotection and societal rejection of very normal and vital sexual desires and needs. One can only imagine the increased severity of difficulties faced by the newly-disabled (i.e., individuals who experience problems associated with post-stroke, spinal cord injury, or multiple sclerosis). Regarding the newly disabled, Bidgood states that:

> They experience the acceptance and sexual expression of their humanity, but having internalized society's concept of the handicapped as asexual and something less than human, they apply it to themselves in their new state. Their concepts of self-worth and self-dignity are lessened or overturned, their sexual self-images distorted, and they become embittered more emotionally and psychologically handicapped than they are physically. (p. 2)

Most of the recent interest and openness in discussing sexuality and the handicapped is restricted almost exclusively to health professionals. Hence, it is critical to realize that the struggles and fears experienced by today's handicapped youth are just as dramatic as those experienced by disabled adults who grew up in the thirties, forties, and fifties. Even with the advent of increased social exposure, familial, societal and personal misconceptions still remain strong. Unfortunately, a severely burned face or an atrophied body is still regarded with fear and non-acceptance.

With this background in mind it is now appropriate to discuss some factors to be considered in sexual counseling. Most of my counseling experience has been with adolescents and adults with cerebral palsy. The degree of disability and level of intelligence varies from client to client. As has been described, however, perhaps more significant than their limited physical functioning is their social and personal immaturity. Our organization runs an extremely active teen and adult group for 200 cerebral palsied individuals ranging in age from 13 to 65. Aside from activities such as bowling, dancing, choral groups, and community day trips, we also sponsor yearly trips to Bermuda, the Bahamas, or Puerto Rico, and shorter trips to Cape Cod. This allows us vast opportunities to observe the presence or absence of independent social skills.

The problems we have observed are all too similar. Few handicapped persons by the age of 40 have ever seriously kissed a member of the opposite sex, yet all cling to the fantasy of being married. Except for a small number of our highly intelligent or mobile members, surprisingly little sexual or social initiative occurs among members; rather, clients' social skills materialize through initiation by our volunteers. This suggests that engaging in such playful interaction at the instigation of another proves far less threatening than facing potential self-inflicted rejection by pursuing relationships with other handicapped group members on one's own. The few relationships that do develop resemble adolescent puppy love and exist only during our meeting; few members initiate dating outside of the group. Even among our highly intelligent members who are able to master the emotional aspects of such relationships, discomfort and insecurity with sexuality are quite evident. Such members tend to be severely handicapped and lack knowledge about sexual alternatives. Rather than having to ask for assistance, they will often sublimate their desires and restrict sexual activity merely to holding hands. The final factor which limits sexual behavior of our group members is simply dynamics. Even though belonging to this group is the only social opportunity available to them, the fact that the group is composed of 200 people with diversified ages, intelligence, and severity, with an imbalanced male/female ratio, means that not everyone is going to be able to find a suitable mate.

Our group in many ways represents a microcosm of the sexual problems encountered by the disabled. Our members are limited through various combinations of inadequate social skills, physical dependency, lack of available partners, and overprotective families. Sexual counseling is a critical need.

In the past ten years interest in dealing with sexuality and the handicapped has sharply increased. Pioneered by the work of Theodore Cole with the spinal cord-injured and Sol Gordon with the mentally retarded, health professionals have come to recognize that the handicapped, regardless of their disability, have the same sexual drives and needs as the nonhandicapped. Further, with appropriate help they are capable of maintaining equally mature emotional relationships. Aside from these attitudinal changes, attempts are also being made to effect substantive change in the asexual/hypersexual stereotype.

With the advent of de-institutionalization, mainstreaming, and the rights for the handicapped movement, health professionals have come to recognize the need for sexual counseling outside of the rehabilitation setting. Handicapped adults are now living in community half-way houses, maintaining jobs, and participating in more social activities (Shrey, Kiefer, & Anthony, 1979). They are more aware of their sexual and emotional desires; yet they also experience a sense of frustration due to their lack of skills in fulfilling these drives. Group discussions dealing with dating, marriage, birth control, and sexuality have proven to be an excellent outlet for expressing frustrations.

In spite of the recent interest and openness with this issue, validated research remains scarce and active implementation is still hesitatingly and inconsistently offered. Although sexual counseling is rarely given priority within the rehabilitation process, for the client sexual functioning is a primary concern (Cole, 1972). For those not newly disabled, opportunities for social interaction as well as group discussions are on the increase; but even these do not deal with the fundamental insecurities unique to each individual. It is poor body image, limited social skills, and fear of rejection which ultimately block independent sexual exploration, rather than simply limited knowledge concerning birth control or accessible dating facilities.

Perhaps the failure of health professionals to offer an aggressive treatment program lies within our own existing insecurities. Sexuality is not an easy issue to deal with; oftentimes the counselor is more nervous than the client. Yet, no one will deny that assistance in this area is vital. Therefore, I would like to discuss some approaches I have found which greatly facilitate the sexual counseling process. My suggestions are geared to the unique needs of adolescents and adults handicapped from birth; however, many of them will also apply to the newly disabled.

Before a counselor can begin to offer effective sexual counseling, he/she must possess certain basic attitudes. All too often counselors have approached me completely mystified as to why their efforts were poorly received by a client. They have reported that the session held a continuing air of tension and that the client never initiated a return visit. I have asked such a counselor if he/she ever used the word "fuck" within the session. My request engenders an uncomfortable silence and oftentimes a timid blush. The individual quietly replies, "No, that would be unprofessional, and besides I'm too embarrassed to use such a word."

I realize that this has been said time and time again, but it is imperative that sexual counselors be comfortable with their own sexuality before they can even begin to counsel others. If they are unable to ask the client if he/she masturbates, then they will be lacking information vital to the counseling process. Counselors must be able to discuss

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calmly and confidently every possible sexual alternative regardless of how unacceptable it may seem to them. Alternatives such as engaging in oral sex, using a vibrator, or hiring a prostitute may prove to be the only possible sexual outlets, but such methods may be sacrificed if the counselor is too uncomfortable to suggest them. Contrary to many beliefs, sexual counseling is not merely assisting the client to gain enough confidence to date (although this is indeed an important element), it is also exploring all available sexual options with the client. Once counselors feel comfortable with their own sexuality, they are ready to begin to deal with the true focus of the counseling process: the client.

As a first step, you as the counselor should try to assess your ability to empathize with your client. Many have found it helpful to actually experience being disabled--to live in a wheelchair, not just for a day but for a whole week--and have found it to be much more difficult than they imagined.

With this increased sensitivity you should try then to understand how you would feel as a disabled individual coming for sexual counseling. Consider the person's probable resentment toward you as an able-bodied person, capable of independent sex and an active social life. This is an important issue which is rarely considered in the counseling process, yet it may be the key to establishing a trusting relationship. Helping your client to air these resentments (indeed, there are many) will result in a much more honest and comfortable level of communication.

Second, it is important to consider the client's level of comfort in discussing sexuality. Remember, for years your client has been refused opportunities to discuss such concerns, let alone acknowledge his/her very real sex drives and needs. Such discussions may therefore prove extremely threatening and uncomfortable unless they are approached with the highest degree of sensitivity. Further, how much does your client understand about sex? We take it for granted that by 21 years of age everyone knows that a man and a woman engage in intercourse and that through this act fertilization occurs, but do not be surprised if your client is totally unfamiliar with this.

Third, consider the client's comfort level in relationship to his/her religion, ethnic and racial background, as well as perception of gender role. Can a male client comfortably discuss with a woman counselor his inability to maintain an erection? If your client is bound by religious beliefs, can he/she consider alternative sexual practices which may be in opposition to accepted doctrine? Does your male client feel he must be the aggressive sexual partner in order to establish his masculinity, when in fact this is physically impossible?

Finally, you should consider your choice of sexual language. Terms such as vagina, penis, or menstruation may be totally unfamiliar to the client who is used only to such words as pussy, dink, or my friend. It took me several sessions to adjust to this facet of counseling. In fact, I locked myself in a room and recited these words into a tape recorder until I felt comfortable using them. Such considerations are crucial and can make the difference between effective and ineffective sexual counseling.

The next element to consider is the counseling process itself. Although your approach will often vary from client to client depending on the individual's unique needs, you should still adopt a basic framework. Many have found it helpful to establish with the client, in writing, deficits, goals, and resources to fulfill these goals (Shrey, Kiefer, & Anthony, 1979). Such a method may prove especially effective for the client who needs structure, concrete objectives, and the immediate gratification that occurs upon completion of a goal. However, my approach is more informal and far less structured.

Directness is essentially the key. Remember, clients are coming to you replete with years of misconceptions, inhibitions, insecurities, and fears. The initial stages of counseling are the most delicate and therefore require the utmost sensitivity.

With the client who is single, I initially try to facilitate the client's appreciation of the importance, beauty, and normalcy of his/her sex drives and needs. Once I sense the client's acceptance of and trust in me, as well as his/her recognition that fulfillment is possible, we begin to work far more directly. I bring to surface issues such as previous sexual experience, experience with masturbation, poor body image, overprotection from the family, and lack of societal acceptance. Although initially taken by surprise, the client quickly responds to my openness. With the establishment of this atmosphere, we can then discuss the client's informational needs and begin working on concrete solutions. Together we explore the client's existing social skills, the effects of physical limitations on the client's ability to perform sexually, and the existing social outlets and problems encountered in taking advantage of these. Oftentimes counseling takes the form of just explaining intercourse, male/female differences, menstruation, birth control, or causation of pregnancy. Again, the handicapped individual's ignorance is often due not to retardation but simply to familial and societal overprotection and failure of parents to acknowledge their child's sex drives. More explicit sexual counseling is then offered when the client has formed an intimate relationship.

For single male clients who present severe sexual adjustment difficulties, I have recently begun to use the services of prostitutes as an alternative sexual outlet. Such a dramatic step has proven to be especially effective for the male who has had little sexual contact, possesses poor social skills, and is limited in the availability of social partners. Most important, these clients tend to possess a highly intensive sexual drive; satisfaction becomes of primary concern. Once the client experiences a fulfilling sexual experience he is then often capable of initiating a more mature relationship (Rehab Brief, 1978). The confidence gained is immeasurable.

For the couple seeking premarital counseling my services are of a different nature. However, directness is once again the key. My goal in such counseling is to confront the couple with the realities of marriage. We discuss in depth such issues as their financial resources, the stability of their jobs, the importance of physical contact for comfort as well as for sex, the extent of their dependency on family and significant others, the implications of having children, contraception, and the effect of their marriage on their families. If through counseling we determine that the couple will still maintain total dependency on their family for finances, housing, and emotional as well as physical support, then I tend to discourage the decision to marry. The realities of their lifestyle do

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not allow a marriage but rather simply an alteration in their living arrangement. The harsh truth question, which they must confront, is what would happen to their marriage if their parents were no longer able to care for them? Most likely the marriage would disintegrate as they would no longer have the strong support they needed. Further, the foundations of such a marriage would be weak as the couple would never form the bond created through an independent marital relationship. No matter how idealistic or modern we are in our thinking, the reality of the commitments of marriage could not be satisfied under such circumstances.

If the couple decide to marry, I often suggest that they spend a trial weekend together before the marriage (providing that they are independent enough to do this). Hotel reservations are made, and my husband and I accompany the couple during the weekend to offer support if it is required. This allows them the opportunity to grow comfortable with one another sexually as well as to discuss their insecurities, doubts, and sexual difficulties while the experience remains fresh. The moral implications are obvious; however, many are willing to sacrifice these in order to ease their entrance into marriage.

The ability of health professionals to recognize and discuss the very vital sexual drives and needs of the handicapped is just the first step. An aggressive treatment program is required, not only for the thousands of handicapped individuals who believe that they are incapable of a satisfying sexual relationship, but also for their families and the surrounding public who deny them their sexual rights.

Conclusion

Unfortunately, attitudes of hopelessness and denial are typical of many handicapped adults. Similarly, handicapped youth are still being exposed to the familial and societal fears and misconceptions that have instilled this hopelessness. For many--health professionals and disabled--open discussion which confronts and treats these very real issues proves painful, embarrassing, and unproductive. Sexual counselors must take the initiative in confronting the years of internalized myths and insecurities, as well as in preventing their continued development within our disabled youth. Further, counselors must help handicapped clients to balance realistically their expectations against their capabilities. To do this requires empathy, openness to alternatives, and critical sensitivity. With such an approach the sexual needs of the handicapped will come that much closer to being dealt with effectively, and life fulfillment will become possible.

REFERENCES

Bidgood, F. E. Sexuality and the handicapped. Siecus Report, 1974, 2(3), 1-2, 14.

Cole, T. Sex and the paraplegic. Medical World News, January 14, 1972.

Cole, T. M., & Cole, S. S. The handicapped and sexual health. Siecus Report, 1976, 4(5), 1-2, 9-10.

Geiger C. R., & Knight, S. E. Sexuality of people with cerebral palsy. Medical Aspects of Human Sexuality, March 1975, pp. 70, 75, 76, 78, 83.

Rehab Brief. Sex counseling for handicapped persons, an avenue toward intimacy. September 1978, 1(13).

Schaffer, H. The too-cohesive family: A form of group pathology. International Journal of Social Psychology, 1964, 10, 266.

Schneider, E. Human sexuality and the handicapped. Personnel and Guidance Journal, 1976, 64(7), 378-80.

Shrey, D. E., Kiefer, J., & Anthony, W. Sexual adjustment counseling for persons with severe disabilities: A skill-based approach for rehabilitation professionals. Journal of Rehabilitation, April/May/June 1979, pp. 28-33.

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8 PRESCRIPTIVE INTERVENTIONS FOR EXCEPTIONAL CHILDREN

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PRESCRIPTIVE INTERVENTIONS FOR EXCEPTIONAL CHILDREN

Ralph F. Blanco

For those professionals interested in enhancing their repertoire of ideas to aid their clients, a variety of prescriptive strategies is listed according to common diagnostic classifications: aggression, social withdrawal, significant learning problems and others. These interventions range from counseling approaches to simple and effective behavioral programs based upon well-documented learning principles. The concepts reflect psychodynamic, behavioral, and need-motivation theories. Each strategy must be adapted to the particular circumstances in the child's case by the discerning counselor, teacher, or school psychologist.

To extend their effectiveness with handicapped and exceptional persons, it seems reasonable that counselors, psychologists, and related personnel have access to an eclectic range of remedial strategies for promoting change. However skillful these professionals may be in counseling and insight-oriented therapies, they often find it necessary to "manipulate" the external as well as the internal environment of the client. Many field practitioners eventually shed the cloak of a particular therapeutic orientation--rational emotive, behavioral, analytic, Rogerian--and elect to use several approaches simultaneously as the particular case demands. Although it is intellectually satisfying to emphasize a particular theoretical model in a university training program, it is yet a richer and more complex experience to help actual clients through multistrategy approaches.

The author, observing that counselors and school psychologists in particular tend to limit themselves unnecessarily to a restricted range of therapeutic interventions, has become concerned that too much dependence is being placed on (a) special education placement, (b) psychotherapy, and (c) vague generalities like, "Give the exceptional child opportunities to succeed," and, "Provide satisfaction for the handicapped person's unmet needs." Although none of this trio is patently incorrect, one still questions, after diagnostic evaluation and personal interview, if these are the most comprehensive recommendations available to the client. Are professionals long on diagnosis, but short on treatment? Do counselors and psychologists have brilliant insights, but respond with dull-normal treatments? Perhaps the absence of selected and effective prescriptive strategies is the missing link between the professional's grasp of problems and the client's movement toward change.

Obviously no "short, snappy answers" are available except in the heads of desperate people too panicked in their urgency to help their clients to accept the obvious: Complicated problems have complicated solutions. It behooves the professional not only to attend to the insights of the client and the treatment considerations of related disciplines focusing upon a common client, but also to extend widely his/her perspective for prescriptive interventions. Should the legitimate concern about "cook-book" recommendations and their abuses be raised (Blanco, 1971b), one can feel generally assured that these will rarely occur because of the integrity of the professional counselors and psychologists who now survive the rigorous training programs in major universities. What more likely will occur is that professional persons will use such written prescriptions as creative springboards upon which to build even better and more individualized strategies for their clients.

The author, in his concern for developing a wide range of treatment approaches for exceptional children, sought to discover what practices were actually or allegedly in current use. It was deemed impossible for practitioners who worked with the handicapped to consult disparate journals, texts, and theories for each and every client. Thus the author conducted a national survey (Blanco, 1971a), sponsored by the Bureau of Education for the Handicapped, of 1,350 psychologists in Division 16 of the American Psychological Association to determine what strategies they used for particular diagnostic categories. A total of 146 psychologists responded; the males typically had 11 years and the females 13 years of experience in the field of psychology.

The highlight of the research was that respondents submitted a total of 3,700 prescriptive interventions for exceptional children, all classified by the primary diagnosis--retarded, physically handicapped, blind, deaf, emotionally disturbed, and many others. These prescriptions were severely edited by the author according to criteria such as clarity, specificity, theoretical orientation, and the like.

The ideas essentially reflected three psychological positions: reinforcement, psychodynamic, and need-motivation theory. No research data accompanied each recommendation, unfortunately, although literally hundreds of the ideas were obviously drawn from well-documented research in professional journals and texts, and were approaches derived from these three theories. Further strategies and a discussion of the limitations of the study are noted in the book resulting from the survey, Prescriptions for Children with Learning and Adjustment Problems (Blanco, 1972). The book, now in its fifth printing, contains over 1,000 strategies for change.

For the present chapter, the author has selected the prescriptions deemed most suitable for the counseling reader. These strategies to aid exceptional children are listed below, and are considered to be above and beyond common counseling approaches. Many ideas focus on the school environment as that is the environment in which the variables that affect learning and peer interaction might best be observed and influenced by capable psychologists, counselors, and teachers. Embellishment of the ideas is not possible in a single chapter, and for such the reader is referred to the book previously cited. It goes without saying that no strategies should be used prior to psychoeducational assessment or without the discerning clinical judgment of the professional person. There are no more guarantees that any recommendations will be either effective or carefully implemented than there are guarantees that diagnostic texts will produce astute diagnosticians. The professional who uses these ideas bears the burden of responsibility for initiating, maintaining, and evaluating a treatment program based on sound theoretical concepts.

The prescriptions focus mainly on the elementary school-aged child. Since the majority of current elementary counselors and teachers are women, the author has taken the liberty of referring to the counselor/

teacher as "her" rather than "him." The majority of handicapped, learning disabled, retarded, and troubled children are, by contrast, male. To simplify reading, the exceptional child is referred to as "him" rather than "her." The reader helping exceptional children will be required to make such changes according to the particular case.

Readers interested in the application of these prescriptions and their specific outcomes are referred to Case Studies in Clinical and School Psychology (Blanco & Rosenfeld, 1978).

A. Aggressive Behavior--Externally Directed

General Aggressive Behaviors

1. After such an episode, the counselor might try a time-out procedure to allow an aggressive child fewer opportunities to direct aggression toward peers. The child should not be rewarded with a pleasurable time-out experience if he has been aggressive. If anything, the experience must be isolating and nonrewarding so that the aggression is not positively reinforced. The time-out room can be a simple cubicle in the classroom or, preferably, an isolated room elsewhere. Sending the child out in the hall may be convenient, but it has the potential for too many reinforcing qualities from passers-by.

2. As a way of calming down two aggressive children in conflict in the classroom, the counselor can give each of the two fighters a damp rag to wash the opposite sides of a pane of glass, having the children face each other. The instructions would be, "Please wash this window pane. The loser of the fight is the one who smiles, laughs, or giggles first. Please keep looking at the other fellow to be sure that he doesn't laugh first." What usually follows is laughter as well as renewed friendship.

3. The teacher should always be quite specific about what it is she wishes the children to do. Vague instructions such as "Get to work," or "Please behave better," are often misinterpreted by children and can be upsetting in their generality.

4. During the year the counselor/teacher should actively try to build a good relationship with an aggressive child and use this as a

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lever to control the child's aggression. When a good relationship exists, the adult's approval or disapproval becomes important and the child will constructively do things to get her approval. With such a relationship, one can say, "Please don't hit others even if you are angry," or, "It would make me very proud of you if you would avoid hitting so-and-so."

5. The teacher can provide for periodic release of tension or respond to the need for physical movement through having the child perform "helper" activities: distribute books and papers, adjust window shades, run errands, help others, pick up floor scraps.

6. The counselor/teacher can utilize regular, private conferences with the child to discuss the child's need to learn self-control and to offer full recognition when improvement occurs. This time can also be used to discuss academic progress or homework, as well as a shortcoming or two that might be embarrassing if pointed out in front of the class.

7. Before using operant methodology, the counselor/teacher must determine what constitutes a reinforcer for the child. She must find out what it is the child will work for, by asking the child or by observation. If the child is inarticulate or nonintrospective, several rewards may be suggested (reinforcement menu) from which the child may choose. In such cases the teacher should first obtain parent understanding and permission.

Fighting Excessively in School and Neighborhood

8. The teacher should execute a formal sociogram so that if the aggressive child is well-behaved, he is seated with and surrounded by only his friends. Tell the child that he can "earn" time in class to sit with his friends if he is better self-controlled for a period of time, but that this privilege will be taken away from him if he begins fighting once more. Another possibility is to have the child seated directly in front of the teacher so that supervision is immediate.

Verbal Aggression, Ridiculing of Others

9. If the child seems to have a sense of inferiority or ridicules and abuses others, the teacher should develop ego-building activities for him--special privileges, the chance to run errands, a choice of activities, release time for play--that will enhance the teacher-child relationship

and make school a more pleasant place to be. The teacher, in addition to being friendly, must make it very clear that she will not tolerate repeated incidents of misbehavior and may have to take away the special privileges if he is unwilling to try to control himself. Offenses that occur after this might then lead to temporary loss of a favorite seat in the classroom, loss of the opportunity to deliver messages for the teacher, or deprivation of engaging in certain playtime activities, until the child realizes very clearly that the teacher is firm and in earnest.

10. The counselor/teacher can conduct role-playing activities for the child who is overly-aggressive or who ridicules and abuses others. For example, such a child may be required to play the role of a recipient of abuse so that he may perceive how it makes others feel. The child may thereby learn that his own aggressive behavior can be damaging to the self-concepts of others. The counselor/teacher can then take the role of the ridiculing child in order to express her own feelings of defeat and inferiority. This can be done with the total class as well as with one child so that all of the students learn how it feels to be ridiculed, made fun of, or called names.

11. The decision to let two boys "fight it out" in a boxing match, even under supervision, is actually very unwise. In the first place, it can lead to serious injury and a possible lawsuit. In the second place, rather than channel aggression, such a practice enhances it, provokes more aggression, and can possibly escalate into gang reprisals. Third, the boys may come to the erroneous conclusion, TV style, that problems are solved through physical aggression rather than by verbal reasoning, and that "might makes right." And finally, matching with approximate equality the strength and skill of the boys involved is practically impossible.

B. Aggressive Behavior--Internally Directed

Suicide, Attempted or Suspected

12. A suicidal threat or statement by a child should never be taken lightly, laughed at, or dismissed because it seems preposterous or too frightening to consider. If the child is so desperate as to use discussion

of suicide as an "attention getting device," then this demands clinical attention.

13. An attempt should be made to establish a relationship with the individual which allows for a telephone call or visitation by the counselor at the time of crisis or despondent condition.

14. Many of these children have extremely poor self-concepts, are in states of deep depression, and, in some cases, view the environment as hostile and nonrewarding. These children often feel that the world has nothing to offer them except pain, agony, and possible desertion. They frequently have extremely poor relationships with one or both parents. Children who are suicidal cannot be permanently "talked out of it" by parents or teachers since few adults have had the training to comprehend the depth of depression or feelings of foreboding and anxiety that grip the child. If the suicidal child stays at home, he should receive frequent psychotherapy and have continual supervision throughout all hours of the day.

C. Antisocial Behavior

Cheating in School and Games

15. The teacher should attempt to remove the pressure for cheating: grades, perfectionistic demands, excessive parental or teacher aspirations. Tests should be used diagnostically to determine areas in which more instruction is needed, not the worth of the child. Cheating stems from fear, which is in itself a poor motivation for learning. At test time, the teacher should reduce the temptation to cheat by separating the seats of buddies known to "cooperate."

16. A review of the child's academic progress and intelligence scores in relation to work assigned should be undertaken to ascertain if the cheating is a result of unreasonable demands. A private discussion with the child should include reasons why he should not cheat, reasons why he might feel it necessary to cheat, and factors that prevent him from doing his own work. Generous offers for help in learning the material should be included, as well as a clear statement about what will happen in the future if the cheating persists. The teacher should

recognize that the largest single reason for cheating is lack of knowledge, and that remediation of this deficit will pay off instantly.

Lying to Authority and Parents, Dishonesty

17. The counselor/teacher can alleviate lying by (a) substituting frequent praise for criticism, (b) improving the child's sense of individual worth by showing appreciation for his personal assets, (c) assigning responsibilities of consequence, (d) building a feeling of mutual respect, and (e) giving the child opportunities to express his negative feelings orally.

Truancy from School

18. The counselor/teacher should offer help in remediating the dynamic causes of truancy since they are real and severe. She should also remind the child of the legal aspects of truancy. If truancy results in pleasure-seeking activity, then the penalty should be made significant. Truancy should also become an uncomfortable experience for the parents if they have ignored it.

19. Concessions should be made in the child's daily schedule so that some portion of it consists of an activity of the child's own choosing. If other children complain, tell them honestly that this particular child needs special help and they do not, or that they, too, may earn special privileges through work.

D. Oppositional Behavior

20. The following general suggestions are offered for dealing with the oppositional child:

a. Avoid threatening the child.
b. Substitute activities--await a "healthier" climate.
c. Communicate privately and with understanding.
d. Avoid openly condemning him before the group.
e. Assign tasks that he can achieve.
f. Display honest friendship and interest.
g. Praise good behavior.
h. Ignore, as far as possible, unacceptable behavior.

Disobedience to Teachers, Parents, or Authority

21. The counselor/teacher can set up a program that outlines clearly the consequences for being disobedient and the rewards for being obedient. The former may deal with deprivation of privileges and the latter with their return, with more material rewards, or with social approval.

22. Careful forethought in planning classwork tends to enhance orderliness and obedience. The instructional program should be organized so that children are kept actively learning and too busy to be disobedient.

23. Self-direction should be encouraged. Although teachers are the leaders in the class, a democratic leader gives children opportunity to make rules and regulations for their own conduct, and encourages pupils to help plan programs and activities. Teachers should allow children to solve problems at their level of functioning, even though it involves allowing them to make mistakes. Behavior of children is determined in part by the social approval of the group. When the group has defined its own rules of conduct, individual children are more apt to abide by these rules.

24. Starting on a prearranged day, whenever the child breaks a rule made by the classroom teacher, the teacher should quietly tell the child to go to an isolation room (any relatively bare, quiet room) where he must remain until told to return. The period of isolation should last 20 to 30 minutes. The teacher must be consistent and carry out the punishment without nagging or complaining. Initially the child may spend many minutes in the isolation room, but he will quickly learn to conform in order to avoid isolation if the teacher conscientiously follows the plan. The punishment is fair because it is the child who makes the choice of whether to mind and stay in the classroom, or break the rules and suffer the consequences.

25. It is important to determine an approximate mental age of the child in question from recent scores on intelligence tests, group or individual. In general, to estimate a child's expected reading grade level, one should subtract about five years from his mental age; his instructional reading level will be about one year below his reading test score.

The teacher should then adjust academic expectations for the child's achievement accordingly, which is usually downward (to everyone's relief).

Running Away

26. Runaways are found at every social class level. Poor parent-child relationships are usually the cause of a child's running away. The situation may have reached the point where the child runs away to save himself from physical abuse or severe rejection. Or he may choose running away as retaliation for bitter or traumatic disappointments. In most cases, persistent and chronic runaway behavior requires psychotherapy, perhaps residential treatment, and very likely, family therapy. The potential for harm befalling a runaway child is relatively great, so that every available authority should be used in determining his whereabouts. It is recommended that the parents communicate with every friend or relative of the child with whom he might possibly have contact. They should request the local juvenile authorities to assist in the search for the child. They should also post notices in "underground" newspapers for the child to "Call home, collect."

27. Students should be counseled to recognize the following concepts concerning running away:

- a. The act is commonplace, at least in fantasy, for most adolescents.
- b. The act is symptomatic of other disturbances.
- c. The problems involve the behavior of people other than just the child; running away is a reflection of the problems of everyone concerned, and solutions are complicated.
- d. The consequences of running away are, realistically, to the student's disadvantage; conversely, his remaining within the home situation usually has practical, economic, and operational advantages which may appeal to the student's self-interest until he is old enough to care for himself.

E. Isolating Behavior

28. The counselor should have an early parent conference to determine the frequency and extent of the withdrawn behavior, i.e., if it is situational (just at school), if it is transitional, if it is temporary. If the behavior is chronic and operant under practically all conditions, the child should be referred to a mental health clinic. The following recommendations are given to help school personnel help the withdrawn child:

a. Involve the child in small group activities.
b. Give shortened assignments, frequent breaks, and free time for talk.
c. Place the child with friends; avoid physical isolation.
d. Allow more time for response. Let the child practice his answers at home prior to coming to school and then allow him to give the teacher his list of "ready" answers.
e. Avoid criticism or reproof.
f. Encourage the youngster to express himself in writing and drawings.

29. Reinforcement techniques are most helpful for this kind of problem. Determine what the child does well, for example, math. Have the child do math on the board and reinforce his successes strongly. Later, have the child teach another child the math on the board so that he has to talk both to the child and to the teacher. Reinforcement should be given consistently at first for the performance of relatively simple, intact tasks, very gradually building up to other more complex modes of socializing behavior.

Excessive Fantasy, Daydreaming in School

30. The counselor or teacher should interrupt the fantasy and daydreaming by calling the child's name, asking him to recite or contribute often, standing near him, touching him, or asking his opinion.

31. The teacher and child can make a "contract" whereby the child completes a certain amount of an assignment (so many sentences or problems) within a specific time limit, reporting to the teacher when he is

finished. The assignments and time limits can be gradually extended. The teacher should reward performance up to the contracted level with something the child likes.

32. Classroom assignments should be very short, 5 to 10 minutes long, depending on the age of the child. Appoint an easygoing, friendly peer to be a "partner" to the subject, to draw him gently into classroom reality. Have the partner do school work with, not for, the subject, and maintain responsibility for the child during lunch and recess.

Shyness in School and at Home

33. The child should only be called on to recite before the class when the teacher has prior knowledge that he knows particular material exceptionally well.

34. Some of the other children in the classroom should be taught the techniques of social reinforcement so that they, too, can listen to and praise the shy child when he performs even minimally.

35. This youngster should be included in a peer group counseling session that focuses on communication, on drawing each member of the group into the discussion. The group should be carefully picked so as not to be too threatening to the child.

36. An investigation should be undertaken to determine if there is some realistic basis for the shyness. Is there a speech defect or physical characteristic which embarrasses the child? Can this condition be corrected or minimized? Has the child been punished excessively at home for being loud or noisy or inquisitive? Can the discipline techniques at home be modified? A great number of once-shy children become very talkative adults.

37. The parents should ignore the nonverbal communications of the child and never speak for him. He must make his needs known through words or complete sentences in asking for favors, dessert, or permission to play. Parents/teachers should avoid asking the child questions that can be answered with "yes," "no," or a shrug. Other siblings should also be taught not to interpret or speak for the shy child.

Inhibition in Motor, Language, and Social Areas

38. Gym instruction should be provided to improve motor skills and enhance a sense of confidence in body movement.

39. Group participation might be effective if it contains an element of competition which is nonthreatening to the child. Joining such activities as Cub Scouts, Boy Scouts, day or overnight camp, Little League, or church groups might be good for such children.

F. Dominance and Submission

Boasting, Attention-Seeking

40. Several strategies can be utilized with an attention-seeking child:

   a. Recognize particular skills and divert his energies to those skills whenever possible.
   b. Praise worthwhile actions and attitudes.
   c. Privately discuss the effect of his actions upon others.
   d. Assign him to a group in which he must be primarily a follower.
   e. Give him special, challenging assignments.
   f. Use a sociogram and place him next to friends, contingent upon quiet behavior.
   g. Ignore annoying behavior when possible.

41. Role-playing some boastful behavior by others in the class or by the teacher may help the child in question become more sensitive to his impact upon others. Try taping his voice for playback.

42. Focus class attention on the child daily in whatever suitable fashion possible, i.e., reading aloud, "show and tell," passing out papers, taking care of class plants or animals with much commendation, and token rewards for any successful performance. Meet his need for recognition and attention by providing him with exactly what he needs: recognition and attention.

G. Dependence-Independence

43. For the dependent child counselors and teachers should do the following:

- a. Provide role-playing situations that portray more mature roles.
- b. Encourage participation in games and sports.
- c. Encourage expression through creative art and writing.
- d. Hold student-teacher chats pointing out areas of growth.
- e. Delegate responsibilities of a leadership capacity on occasion.
- f. Group the child with a partner or small group to work on a special class project.

44. The teacher should give small assignments that can be accomplished successfully rather than large comprehensive ones that might be overwhelming.

45. The child should be required to make decisions, e.g., choose between two shirts, ties, or dresses to wear. Gradually the selection should be increased from two items to a whole group of items. In general, have the child start by making decisions which are safe and easy and progress gradually to ones that are more involved.

H. Affective Behavior

School Phobia

46. The parent should be allowed to bring the child to school and sit near him. Let the child stay in school 15 minutes the first day with the parent, 20 minutes the second day, and so forth, as a way of desensitizing him to the experience. Gradually increase the time in class and phase the parent out of class gracefully through successive approximations.

47. If the mother's anxiety is reinforcing nonattendance, (a) have the father instead of the mother bring the child to school daily; or (b) use school personnel, preferably his teacher, to bring the child to school; and (c) later have the neighborhood children walk with the child to the bus or school daily.

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48. A child's absence during a significant block of course work can trigger school phobia. Anything which can be done to make school less anxiety-arousing will be helpful. Provide extra help for make-up work, private tutoring, and opportunities for personal counseling.

49. For older children especially, teachers/counselors should work along the lines of desensitization and successive approximations toward the final goal. These procedures apply to cases where there is no appropriate medical intervention, and where psychotherapy is unavailable or rejected. Begin instruction at the tutor's home at regular times during the day or week, with increasing exposure to the child's teacher if possible. Alter the physical environment when the child is ready by moving the "classroom" to a nearby library, church, or other building. Eventually the formal teaching period should be attempted within the school proper, with the final goal being gradual integration in the class. Parents should stay relatively divorced from this technique. The tutor and child together should decide when moves will be made. At the beginning of this plan, the youngster should be counseled about the plan, the expectations for him, and his responsibility in guiding his gradual integration back into the school.

50. An extremely anxious child should not be forced to attend school even though being at home will, unfortunately, provide many reinforcements. The child's panic testifies to the seriousness of the dependency problems as well as to likely defects in the family relationships. Family therapy may have to precede getting the child back to school. Forcing the child back will indicate to the family that there is no longer any problem when it is actually masked only temporarily.

51. The father should be encouraged to play a stronger role in the family if he has been passive and/or relegated into insignificance. He should visit the school, take the child with him shopping on weekends, show the child his place of work, and contribute his interests to the conversation at the dinner table. The counselor should tell him this in front of his wife and support his new efforts to help his own child to mature.

Anxiety About Tests, School, and Failure

52. Teachers should be cautioned against exposing any student, especially an anxious one, to ridicule or sarcasm. A student reporting that he "froze up" on a particular test should be listened to sympathetically and, if at all possible, should be allowed a retest under less stressful conditions. Emphasize that the primary function of testing is to promote learning rather than to evaluate. Desensitization by suggestion is also frequently helpful. The teacher may help by having the children relax physically and envision some calm and pleasurable pastime prior to testing.

53. The counselor should discuss the youngster's fear of tests. Parents should be requested to provide a special place for studying. The teacher or counselor may help the youngster to develop good study methods and act as a reinforcing agent for strengthening them. A "study-buddy" system is helpful in preparing for tests if the buddy (other student) is capable and service-oriented.

Depression--Mild, Moderate, Severe

54. Behavior therapy can be utilized to help children who are victims of depression to develop new, more constructive behaviors. Utilize assertive training to help the adolescent control more areas of his life and produce effects upon others for his own advantage. All spontaneous or requested behaviors involving activity, work, action, play, movement, conversation, projects, discussion, and/or participation should be consistently and heavily reinforced. Interrupt the child's depression with instruction, demands, and assignments, and set time limits for completion of work. Offer tokens for any variety of activity to be traded by the child for money or desired possessions or privileges. The child should be given responsibilities and should have obligations to groups and parents.

Inferiority

55. To help a child overcome feelings of inferiority, the following suggestions are offered:

a. Inspire confidence in his own ability.

b. Supply work to help him "catch up" with the group.

c. Test specific areas of achievement and design a program at these levels.

d. Capitalize on strengths shown by tests and interviews.

e. Let the child do something for the teacher/counselor.

f. Express appreciation for effort.

g. Appoint him to "head" a committee.

h. Include him in a spirited special panel on "emotionally-charged" topics such as crime or pollution.

i. Include him in a group whose work merits special recognition.

j. Send a note home telling of good effort.

k. Involve him in class discussion, questions, activities.

l. Develop observation projects involving social behavior--in the cafeteria, halls, downtown, in theaters--teaching him to watch for desirable and undesirable behavior in others.

I. Cognitive Dysfunction, Learning Failures

Learning Inhibition Due to Emotional Difficulty

56. The teacher should establish a reinforcement schedule at school to reward the child's completion of his work. Give tailor-made homework that is within his rather feeble endurance and interest span. Find out through interviewing what interests the child has and attempt to match these with curricular experiences and assignments.

57. The teacher/counselor should try to discover the source of the child's emotional difficulty and conflict. Use other children in the class extensively for tutoring the child. Secure or devise educational games that relate to the child's areas of interest, or at least relative competence, and center the studies around these. Create a relaxed atmosphere in the classroom. Try to meet some of the child's emotional needs for affection or recognition within the school setting.

58. The teacher should attempt to shape the child's behavior by positively rewarding acceptable behaviors and ignoring the unacceptable. Punishment for inappropriate behavior should be curtailed because just

attending to it in many cases actually reinforces the behavior that the teacher is trying to extinguish.

59. For the older child who finds it impossible to adjust academically and socially to a regular school placement, an alternative or vocational school situation might be the most appropriate educational setting, regardless of high intelligence.

60. Anxious parents should disengage themselves from their child's academic work; the school should assume direct responsibility for educating the child. The parents should concentrate instead on increasing the child's feelings of adequacy in nonacademic areas by involving the child in activities in the home and working to promote closer parent-child relationships.

Underachievement--Passive-Aggressive Behavior, or Poor Educational Background

61. Several underachievers can participate in a group discussion with the counselor. The counselor should be flexible and understanding, and allow the youngsters to ventilate their frustrations, disappointments, and negative attitudes toward adults and the educational programs. The aim would be to help such children recognize their own contributions to the problems.

62. The counselor/teacher should try to obtain the confidence of the child by being genuinely concerned about his underachievement. Discuss his potentials and his weaknesses with him. Decide on a school or subject area goal with him and plan a realistic program starting at his present level of knowledge and ability. To motivate him to achieve a certain amount each week, develop a reward system whereby he can earn so many tokens or marks in one week. Set a goal of a certain amount of tokens for a "prize" that the child desires. The parents can be included in this planning and can supply the prize. An easily attainable goal should be set so that the child does not feel defeated initially.

63. If the child has difficulty in writing but does not have problems with oral expression, the teacher can have him dictate stories to an aide or into a tape recorder, to be typed later by a friend or the parent.

64. Differentiated assignments are needed for an underachiever since he cannot maintain the pace of the class, even if he is quite bright.

65. The teacher can ask the child to work as a personal favor to her if there is a good relationship. Personalize the request and tell him that you hope he will do one academic task well today. Tell him that he can relax all the rest of the period. Request these half-hour productions for a week or so, expecting no more. Then try for a 45-minute spurt that includes some reward.

66. The child should be given private instruction in good grooming and personal care; he should be taught how to shake hands, dress, and become friendly with others. Give him the chance to clean up his hands and comb his hair. React positively even to minimal efforts. Such a child usually has a very low self-concept.

67. The underachiever from a culturally deprived background can be rewarded with tokens for progress. These tokens can be "cashed in" at the end of the day for candy or other rewards. To insure accuracy and neatness, tokens can be added or subtracted from the child's "bank." (In one school where this was tried, it was surprising to find some of these children cashing in their tokens for school materials--construction paper, paste, and even mimeographed assignments--in order to continue school work at home.)

Reading Underachievement

68. The dyslexic child should be encouraged to learn through movies, TV, other visual aids, records, lectures, field trips, and listening in class.

69. Shop reading materials should be adjusted to a very low reading level. A boy in ninth-grade shop class reading at a fifth-grade level must have a shop manual written at the lower level if he is to succeed. A "translation" assignment such as this might be an interesting task for a superior student.

Arithmetic Underachievement

70. Lined paper turned sideways is a helpful device for the child who has difficulty writing the numbers for arithmetic problems in straight columns and rows.

71. It is suggested that a calculator be used in remedial work in arithmetic. This machine catches the interest of a youngster and in most cases encourages him to work with numbers which have been previously unpleasant for him.

Distractibility, Short Attention Span

72. An isolation booth or "office" should be set up in the classroom where this youngster can be placed when his hyperactive and/or distractible behavior becomes too severe. Such a booth reduces impinging stimuli and helps the youngster to calm down. It is important that such an "office" be considered a positive thing in the classroom rather than a punishment.

73. Distractors should be limited. Do not seat the child near windows, colorful bulletin boards, or open doors. At times, allow the child to work quietly by himself in the back of the room, not as a punishment but as a means of helping him complete his work. The teacher might also turn the child's desk toward the wall if there is no study carrel in the classroom.

J. Impulsive Behavior

74. A child who is low in impulse control, regardless of etiology, often responds readily and sometimes enthusiastically to a behavior modification program which rewards him for firm self-control. First, observe the child and obtain a base-line rate about how many times he gets out of his seat, hits others, speaks out of turn, or does not attend to the lesson. Then present him with a chart of each day and a set of potential reinforcements (candy, M & M's, gumdrops, stars, free-play, marks, or anything the child finds rewarding). Explain the behavior-shaping program to him. Reward generously at first for approved behavior. Do not punish his relapses; just reinforce the positive developments. Explain the system to the administrator, the child's parents, and the other children in the class before it begins. Initially pair the reinforcers with praise, move gradually into using intermittent reinforcement, and later use just verbal approval.

75. A child with problems in self-control may need evaluation by a pediatric neurologist and possible medication depending upon the source of the problems. The child may require (a) special class placement for emotionally maladjusted children, (b) setting of firm and clear limits for his behavior, (c) development of appropriate academic goals within his ability and current achievement levels, and (d) constant monitoring by the teacher to help him focus on the lessons at hand. Recommend that both of his parents obtain counseling to help assess how their own behavior may be contributing to the youngster's problems.

Compulsive Behavior

76. Such behavior is difficult to reverse without therapeutic intervention. The teacher and the parents can offer only palliatives such as minimizing and discouraging perfectionism, deemphasizing criticism, and pointing out their own imperfections. In behavior therapy, the execution of ritualistic behavior may be requested, perhaps demanded, so that the extinguishing of such behavior may begin, i.e., the behavior may exhaust itself through lack of reinforcement (negative practice).

Tantrum Behavior

77. The child should be physically removed from the situation where the tantrum is occurring. Audiences are necessary for the continuance of tantrums. To attend to a tantrum in any way is to reinforce and sustain it.

K. Mild Mental Retardation--Educable

78. Attempts should be made to integrate retarded students into as many regular school activities as possible--assemblies, sports, clubs, special events, visits to cultural centers, and academic classes. Arrange with a regular class teacher to have the retarded students sit with her students during lunch time. Plan gym, playground, and other joint activities with regular classes of comparable age.

79. In the educable retarded classes, instruction should be individualized to the levels, skills, and limitations of each student in each

academic, motor, and social area through personal observation, achievement testing, and reliance upon psychometric evaluation. Teach the children at their respective levels to overlearn, to master the predetermined academic material within their abilities. Special help, individual or in small groups, should be given in areas of marked deficiency by the teacher, educational aide, or other specialist.

80. Each child should be allowed to work at his independent level much longer than the average student so that overlearning may occur readily. A grasp of well-learned knowledge reinforces the child's feeling of competency and reduces feelings of inferiority.

81. This child should be allowed as much time as possible to express himself verbally since he is apt to react negatively to demands for rapid or perfect responses. Do not permit him to use body language, grunts, or finger pointing as substitutes for verbal expression.

82. Directions must be well-structured, couched in appropriate language, clear, simple, and explicit. Space verbal instructions and speak them slowly. Do not give long verbal instructions that require excellent auditory memory.

83. The teacher/counselor should plan the curriculum largely around living needs: health, home and family decisions, getting along with others, counting, making change, budgeting, cooking, sewing, crafts, manual activities of a practical nature, leisure activities, safety, and prevocational activities. Discuss feasible vocations and the personal traits needed in these jobs.

84. A retarded child will need many explanations and demonstrations to learn social skills. Role-playing might be helpful to clarify social areas in which the child is uncertain of his actions or of the demands of others. Having a child assume a role helps him to develop further social awareness and knowledge of how to act. Teach the child such skills as how to ask for directions, tell about being lost, telephone, ask for help from adults, describe where he lives, introduce his parents, shake hands.

85. After prevocational experiences, the teacher should involve the child in a more advanced vocational experience, selecting specific activities within the world of work which will train the student for a real

job. Salad-making, bus-boy, other restaurant responsibilities, janitorial jobs, car wash, laundry and hospital work, gardening, farming, and sheltered shop are all suitable as initial experiences for the mentally retarded.

86. The parents should be helped to understand that the child will still require a great deal of patient help even after he has been placed in a retarded class, and that school specialists or some agency professionals are available to assist with problems relating to child-rearing practices, discipline, jobs, dating, teenage values, and possible marriage.

87. The child can be provided with a list of routine home tasks, carefully laid out in sequence for designated times. If the jobs are listed by pictures, each can be checked off by the child as it is accomplished.

88. The parent should take the child to the library to borrow books appropriate to his mental age. The parent should read to the child using the content of the book as a means of helping to develop vocabulary by discussion and recall. As a rule of thumb for the educable retarded child, select the following materials for his chronological age:

a. Preprimers for ages 6 through 8.
b. Primers for ages 7 through 10.
c. Primary readers for ages 8 through 11.
d. Second and third grade readers for ages 9 through 12.

L. Blind and Partially Sighted

89. Special materials for the visually handicapped are "talking books" (books on record or tape), "live" reading services relating to homework by an adult or nonhandicapped child, and taped recordings of lessons.

90. Teaching touch typing is recommended for children of average ability from the fourth grade up. This can become an invaluable tool for children with progressive eye disorders.

91. Guidance services for both the children and their parents should be offered at all levels of the child's education. Also, the Lion's Club,

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Bureau of Vocational Rehabilitation, the local blind association, and the State Department of Public Assistance can sometimes aid the family with proper eye care equipment and medical care in cases of special need.

92. The regular teacher should treat the child as normally as possible and try especially not to overprotect or indulge him because of sensory problems. The child may or may not have mobility problems, but no one should carry the child or lead him by the hand or clothing (except in a fire emergency). Teach other children not to "baby" the blind or partially-seeing child.

93. To reduce a "blindism" of body-rocking, the teacher/parent should establish a reinforcement schedule of giving candy or some material reward contingent upon, say, two minutes of no rocking. Give consistent reinforcement for the child's efforts at self-control for two minutes. Later, raise the requirement of getting the candy to perhaps five minutes of no rocking.

94. Blind children should be given extensive training in the social skill of polite refusal of help, since many kind but infantilizing offers will be extended to them. The more unnecessary help they accept, the more dependent they may become.

L. Deaf and Hard-of-Hearing

95. Preferential seating in the regular classroom near the teacher is recommended for a hard-of-hearing child. The teacher will have to be careful of enunciation, especially of such small words as "a," "of," and "and." Also, the teacher should not drop her voice at the end of the sentence. A caution: Enunciation should not be greatly exaggerated since lip-reading is based upon normal movements of the mouth.

96. For children who refuse to wear their hearing aids or glasses by conveniently "forgetting" them, the teacher should attempt to reinforce the wearing by (a) heavy initial rewards, (b) a chart system for consecutive "wearers" who may earn a weekly prize, (c) withdrawal of privileges for "forgetting."

97. For the partially-hearing, the teacher/counselor/parent should not accept a nod of the head or a one-word answer if the child is capable of producing a better verbal response.

98. Children with hearing problems should also receive extensive eye evaluations since they depend heavily on this sense. They should receive adjustments as doctors recommend.

99. Parents should be made aware that a most common reaction for them is to overprotect the deaf child and that some of this tendency may spring from their own sense of guilt. They sometimes suspect that they have harmed the child in some strange, unknown way and must "make it up to him." Ask them to be sensitive to this and to let their child do practically any activities which normally hearing children do in sports, art, camping, jobs, entertainment, hobbies, and local traveling. If they really want to help their child, they must let him grow up with the confidence that he can solve his own problems in living and the knowledge that he has not been held down by his parents. Some deaf children become angry with parents on just this point and show their rebellion violently. Others rebel, of course, due to the fact that they were never given controls and limits because the parents "felt sorry for them."

100. Adults should not anticipate the needs of the deaf child so that he does not speak and ask for what he requires. It would be far simpler to do everything for the child, but these kindly acts only delay the development of independence and speaking skills.

N. Brain Damage, Motor Impairments

101. Motor coordination skills are often the most seriously impaired in the brain-injured child. Physical therapy is essential to develop to a maximal level what is neurologically intact. Once a semblance of motor control is developed, the teacher may wish to start the child with large crayon movements, working toward more finely differentiated movements as a long-term goal. Sand box activities, large printing, or moving large alphabet letters into place can be effective in aiding motor coordination.

102. Many but not all brain-injured children require highly structured and well-planned classroom activities. It is usually not wise to have a highly permissive classroom atmosphere for either "normal" or handicapped children. In general, vary the program every 10 or 20 minutes depending on the ages of the students involved.

103. Some lessons from school can be continued at home via a reel or cassette tape recorder. Various tape-playback educational devices can be used for those children who need extra training or who learn best through the auditory modality. Adult volunteers could tape their own reading of children's books for new learning.

104. The teacher of teenage handicapped girls might develop a basic course relative to essential life-adjustment skills and home economics, which could become the core for learning all other subject matter. Math, for example, would be centered around money management and such concerns as household weights and measures, while both math and reading would have carryover to home activities and potential employment.

105. Parents should first seek medical and neurological evaluation of the child. Physicians may consider medication knowing that there is wide variance in the specific effectiveness of drugs, especially since placebos are also effective in certain cases (to reduce parent or teacher anxiety). Some impulsive children behave poorly as a result of overprotective practices and not being required to develop better self-control.

106. The parents should be informed not only of the medical, biological, and neurological aspects of their physically handicapped child, but should also learn gradually about the educational, psychological, and social aspects of these problems. These latter dimensions will loom even larger as the child grows older and may require selective educational placement and social training.

Final Remarks

All the previously listed suggestions and prescriptive interventions are, understandably, limited in their application, for what is reasonable and appropriate in one case may be ludicrous in another. The sensitive

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teacher or astute counselor, knowing well the child and his problems, may have an excellent vantage point from which to select the most valid strategies. All interventions must be chosen carefully, applied judiciously, and monitored conscientiously for their effects. Although it would be well to base all professional decisions upon experimentally-verified, research data, such a goal has never been reached. Instead, it is necessary for professionals to make clinical judgments based upon training and experience while focusing on the welfare of the child and the significant variables in his life.

CITED REFERENCES

Blanco, R. F. A study of treatment plans from school psychologists for exceptional children. Final Report, Project No. 482192, Grant No. OEG-0-70-0010(607), Bureau of Education for the Handicapped, Office of Education, Department of Health, Education and Welfare. Philadelphia: Temple University, 1971a.

Blanco, R. F. A focus on remediation in school psychology. Journal of School Psychology, 1971b, 9(3), 261-277.

Blanco, R. F. Prescriptions for children with learning and adjustment problems. Springfield, IL: Charles C. Thomas, 1972. (Revision in press, 1980).

Blanco, R. F., & Rosenfeld, J. G. Case studies in clinical and school psychology. Springfield, IL: Charles C. Thomas, 1978.

9 A DEVELOPMENTAL MODEL OF CONSULTATION FOR EXCEPTIONAL CHILDREN AND YOUTH

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A DEVELOPMENTAL MODEL OF CONSULTATION FOR EXCEPTIONAL CHILDREN AND YOUTH

Marvin D. Wyne

This chapter defines the process of consultation and presents a model of consultation intended as a conceptual framework and an organizing structure for counselors and fellow professionals whose individual and collective services affect the life chances of exceptional children and youth. The conceptual framework is referred to as a developmental model in order to distinguish it from the traditional approach of placing exceptional persons into separate categories in order to provide them with supportive services. A number of the concepts that serve as building blocks of the developmental model are defined. The concluding section presents examples of how the various levels of the model can be applied.

The purpose of this chapter is to outline a conceptual framework for the delivery of consultation services to exceptional children and youth. The intended audience is primarily school counselors, but the proposed structure is equally applicable to any helping professional whose role includes consultation responsibilities for exceptional individuals, groups, and/or their families. Because of the wide variations in meaning and usage, working definitions of consultation and exceptional will be presented prior to describing the proposed model.

Consultation: A Concept in Search of a Definition

The notion of consultation has been associated with the medical and legal professions for many years. It has only been within the past two decades that the term consultation has appeared with regularity in education and mental health literature (Bindman, 1959; Brown, Wyne, Blackburn, & Powell, 1979; Caplan, 1970). Consultation is now a part of the jargon of nearly all the helping professions and is used as a noun, verb, adjective, and adverb--in an impressive and often confusing array of contexts. Gerald Caplan of Harvard University provided much of the early conceptual base for the current practice of consultation in education and mental health (Caplan, 1954a, 1954b, 1956, 1959). He viewed consultation as the following:

> A process that takes place between two professionals--the consultant and the consultee, in which one professional (the consultant) attempts to assist the other professional (the consultee) to solve a current problem or meet a present need that has arisen out of the context of the consultee's professional responsibilities. (Caplan, 1970, p. 19)

Lewis and Lewis (1977) suggest that Caplan's concept of consultation involves equal, two-way communication between the consultant and consultee, with the focus being placed on a third party or situation (e.g., the individual, group, or situation identified as the consultee's professional responsibility). The present author's approach to consultation is founded on the assumption that the consultant and consultee are professional equals. This position is taken with full recognition that the notion of consultation has come to be used in some quarters to refer to many other types of helping relationships which do not assume that consultant and consultee both have professional responsibilities or are equals.

Consultation is a dynamic process. It is a relative term and continues to be interpreted, defined, and applied in different ways by different people. Perhaps, due to the high visibility that the term presently enjoys and the positive valence that the process has in professional training and practice, consultation has undergone a spread of effect. The overgeneralized interpretation of the term and the process has led to fundamental changes in the application of its basic meaning. Consultation is often used improperly to replace terms that are more appropriate and precise. For example, counselors no longer simply meet or talk to parents, they "consult" with them. Supervisors do not provide assistance with curriculum or instruction, they "consult" with classroom teachers. Special educators have ceased to share responsibilities or information with regular educators, they now "consult" with them. School psychologists do not test, observe, and meet with students, or placement committees, they hold a "consultation." Each of these disciplines does in fact engage in consultation, as defined earlier. But it is confusing rather than helpful or accurate to describe the direct delivery of most of their professional services as consultation.

A consultative relationship may be said to exist when the following conditions are met:

1. When the relationship between or among professionals is characterized by the voluntary participation of all parties;

2. When each of the parties is equally free to withdraw from the relationship;

3. When the consultee is free to accept or reject any advice, recommendations, or suggestions provided by the consultant;

4. When the scope of the consultation is temporary and is problem, topic, or situation specific;

5. When the focus of the process is on a third individual, group, or situation.

Note that the consultation process may be initiated by the consultant or consultee, but must be entered into freely, openly, cooperatively, and positively. It is implied that consultant and consultee are professional "equals," although one may be at a higher level professionally in an organizational hierarchy. They are equals because they are both helping professionals with the recognized competence and training to ethically intervene in the life chances of other individuals. If either party perceives that the process is dependent on the administrative authority of the consultant or grew out of incompetence on the part of the consultee, then a truly consultative relationship cannot take place. Most helping professionals act at times as consultants and at other times as consultees. Consultation is not always a function then of formal roles or positions in an organization or hierarchy, but rather is based on a professional's demonstrated knowledge, skills, and competence to deal effectively with specific problems or situations as they arise.

Consultation can take place between two individuals or in a group. It may involve one consultant and several consultees, or several consultants and one consultee. The most common arrangement is dyadic--one person serving as the consultant, the other as the consultee.

Exceptionality: A Definition in Search of a Conceptual Structure

Exceptional persons are defined as exceptional when proper attention to their needs requires special services and resources beyond those normally provided for other persons. The special needs of exceptional individuals are created by measurable differences in their development and adaptive behavior. When these differences in academic performance, personal-social adaptation, physical capabilities, language, vision, and hearing become so marked that individuals can no longer be properly served by the usual programs and services, special resources are required.

Definitions of exceptionality are numerous, but many questions can be raised concerning the most appropriate conceptual framework or taxonomy for describing, distinguishing, and classifying types of developmental deviations and their range. It would be incorrect for the reader to assume that concerns about the conceptual views of exceptionality are only of relevance to special educators and academics behind ivy-covered walls. The view of exceptionality that is held either explicitly or implicitly by the helping professional will determine that person's attitudes and assumptions about exceptional individuals and will generate the methods and strategies used to intervene in the life chances of people with special needs. What follows here is a descriptive comparison of the traditional *categorical* view of exceptionality with the *developmental* view.

Categorical view of exceptionality. The education of handicapped children and youth is a responsibility taken up only recently by the public schools. The dramatic and rapid growth of special services for exceptional populations in the past two decades has led many helping professionals and lay persons to ascribe to this field a conceptual maturity that it does not yet possess. The categorical approach was a natural by-product of the rapid and haphazard growth of the demand for special services for exceptional populations. It was not until the 1950's that schools began serving exceptional children in appreciable numbers. Even then, the heaviest emphasis was on the area of *mental retardation* at the elementary school level. The categorical areas of *emotional disturbance* and *neuromuscular* and other crippling health impairments did not show a notable increase in public school enrollment until the 1960's. The categories of *learning disabilities* and *multiply handicapping conditions* did not receive much serious attention until the 1970's. The categorical area of the *gifted* has yet to be seriously considered by the nation's schools. The demand for more special services and trained personnel resulted in massive federal support that began during the presidency of John F. Kennedy.

Demands for services were made by parent organizations and educator groups on a category-by-category basis--first, the mentally retarded, then the neurologically handicapped (brain injured), followed by the learning disabled, emotionally disturbed, severely handicapped, and autistic. State departments of education, the agencies responsible for administering federal support to local school units, were required to tie their allocation of dollars to these separate categories to account for the proper disbursement of funds. In order for each local education agency to be eligible for special education monies under the separate categorical budgets, it was legally necessary to refer, test, identify, label, and place each exceptional pupil. The labeling of these groups came into widely accepted use at a period when it was generally believed that if we could identify exceptional students and provide them with special teachers, classes, curricula, and instruction, we could eliminate or at least ameliorate mildly handicapping conditions.

> Parent groups leaped enthusiastically aboard the categorical, special class bandwagon. Their lobbying efforts to influence state and federal legislation were highly successful. Most states passed laws mandating the formation of special classes and the employment of special education personnel for the categorical areas of mental retardation, emotional disturbance, and the neurologically handicapped. By 1970, a huge federal-state bureaucracy was solidly in place with a dazzling array of programs which had largely determined the form and substance of special education in virtually every community in the United States. Simply put, it had become necessary to categorize, label, and usually isolate children from the mainstream of the school in order to provide special services to them.
>
> (Wyne, 1979, pp. 105-106)

It has been correctly pointed out (Gallagher, 1972) that the categorical approach aided the cause of handicapped populations in a major way. These seemingly unambiguous categorical labels have helped to establish a solid base of citizen support for exceptional children and youth. Legislators and taxpayers have found it easy to relate to labels such as mental retardation, emotional disturbance, and learning disabilities. Exceptional children were categorized because it permitted special educators to serve groups of pupils with similar problems; categories required the grouping of exceptional pupils that educators believed could and should be served together. But arbitrary and separate categories and labels were never relevant or valid in a developmental sense.

Developmental view of exceptionality. The developmental view of exceptionality is based on an understanding of what constitutes deviations in the course of normal intellectual, emotional, and physical development. *Development* refers to the intellectual, emotional, and physical results of the constant interaction between biological-genetic endowment and the environment. Marked deviations in development produce exceptional behaviors. The developmental view does not call for the elimination of terms such as mental retardation, learning disabilities, and emotional disturbance. Rather, it suggests the need to change the conceptual context within which these terms and labels are used.

The developmental view of exceptionality attempts to account for deviations and variations in normal development without the necessity of relying on categorical labels. The developmental approach allows the helping professional to deal with a difference in one area (e.g., a child who continually exhibits unacceptable classroom behavior) without assigning a label to the child such as emotionally disturbed or mentally retarded. By approaching deviations in normal development in this way, it becomes possible to apply the *continuum of degree* concept.

Continuum refers to the entire range of variations in development and behavior; *degree* refers to the extent to which development and behavior varies qualitatively and quantitatively from the course of normal development. Continuum of degree (see Figure 1) implies that no clearly discernible point on this imaginary line divides normal variations in intellectual, physical, and emotional behavior from variations that might be considered exceptional.

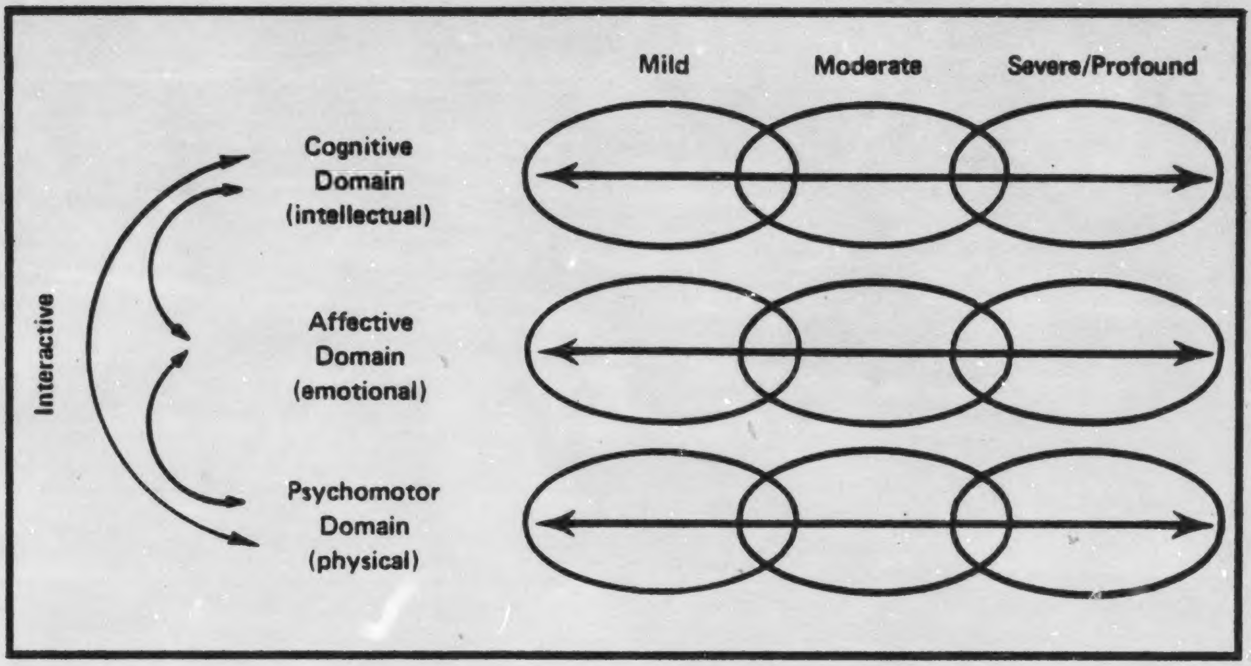
The notion of a continuum of degree of development is intended to emphasize the following features of a developmental view of exceptionality:

1. Deviations in development and behavior vary widely, from near normal (mild) to severe.

2. It is impossible to establish reliable, meaningful cutoffs or divisions between normal and abnormal, mild and moderate, or moderate and severe deviations in development.

3. For each individual there are many continuums of degree. In the broadest terms, each of us has a *physical* (psychomotor) continuum, an *intellectual* continuum, and an *emotional-attitudinal* (affective) continuum.

4. For any given exceptional child, the degree of deviance may be high on one continuum, low on another, and completely absent on a third. Of course, deviance on one continuum affects development and behavior on all others. For


Mild
Moderate
Severe/Profound
Interactive
Cognitive Domain (intellectual)
Affective Domain (emotional)
Psychomotor Domain (physical)

The continuum-of-degree concept postulates that each exceptional child will fall somewhere on this qualitative scale in each of the developmental domains. Functionally the three domains are interactive.

Figure 1 . . Continuum of Degree*

*Used by permission of the author (Wyne & O'Connor, 1979, p. 9) example, a boy born with severe deafness (physical continuum) will surely be affected intellectually and emotionally as he develops.

The continuum of degree concept posits that an eight-year-old boy whose developmental deviation falls near the middle of the continuum (for example, he has difficulty discriminating among basic shapes) may require a longer, and perhaps more intensive, special intervention than a child with milder deviations, but he will not be aided academically in any way by being assigned a categorical label such as learning disabled or retarded. An eight-year-old girl whose developmental deviations place her near the severe end of the continuum of degree requires a different set of special interventions. The interaction between one continuum and another is a most important factor. For example, an eight-year-old cerebral palsied child with severe psychomotor limitations would fall near the severe end of the psychomotor (physical) continuum in Figure 1, but his/her intellectual (cognitive) development might be close to that of a normal eight-year-old. A developmental view of exceptionality attempts to account for deviations along each of these continua as well as for the interaction between and among them.

When the special needs of exceptional individuals are related primarily to deviations in cognitive behavior and development, the focus is on language, memory, reasoning, and concept formation. Exceptional behaviors that are determined to be largely affective in nature may result in special interventions aimed at improving attitudes toward school, feelings of self-worth, self-other orientation, and goal orientation. Deviations in psychomotor development that are extensive enough to create special needs are concerned with physical, sensory, and neurological functions that control all forms of movement and mind-body relations. Though most behaviors can reliably be classified as primarily belonging to one of these three domains of development, all human behavior is dependent upon the interaction among them.

A Developmental Model of Consultation for Exceptional Children and Youth

This section of the chapter proposes a conceptual model or framework for viewing consultation in a dynamic rather than a static sense. The model is based on the assumptions and definitions presented earlier with respect to consultation and exceptionality. The continuum of degree diagram depicted in Figure 1 is the conceptual basis for the developmental model of consultation for exceptional populations. When the dynamic notion of a continuum is applied to the design and delivery of consultation, it becomes possible to conceptualize an almost infinite number of types and levels of consultation (see Figure 2).

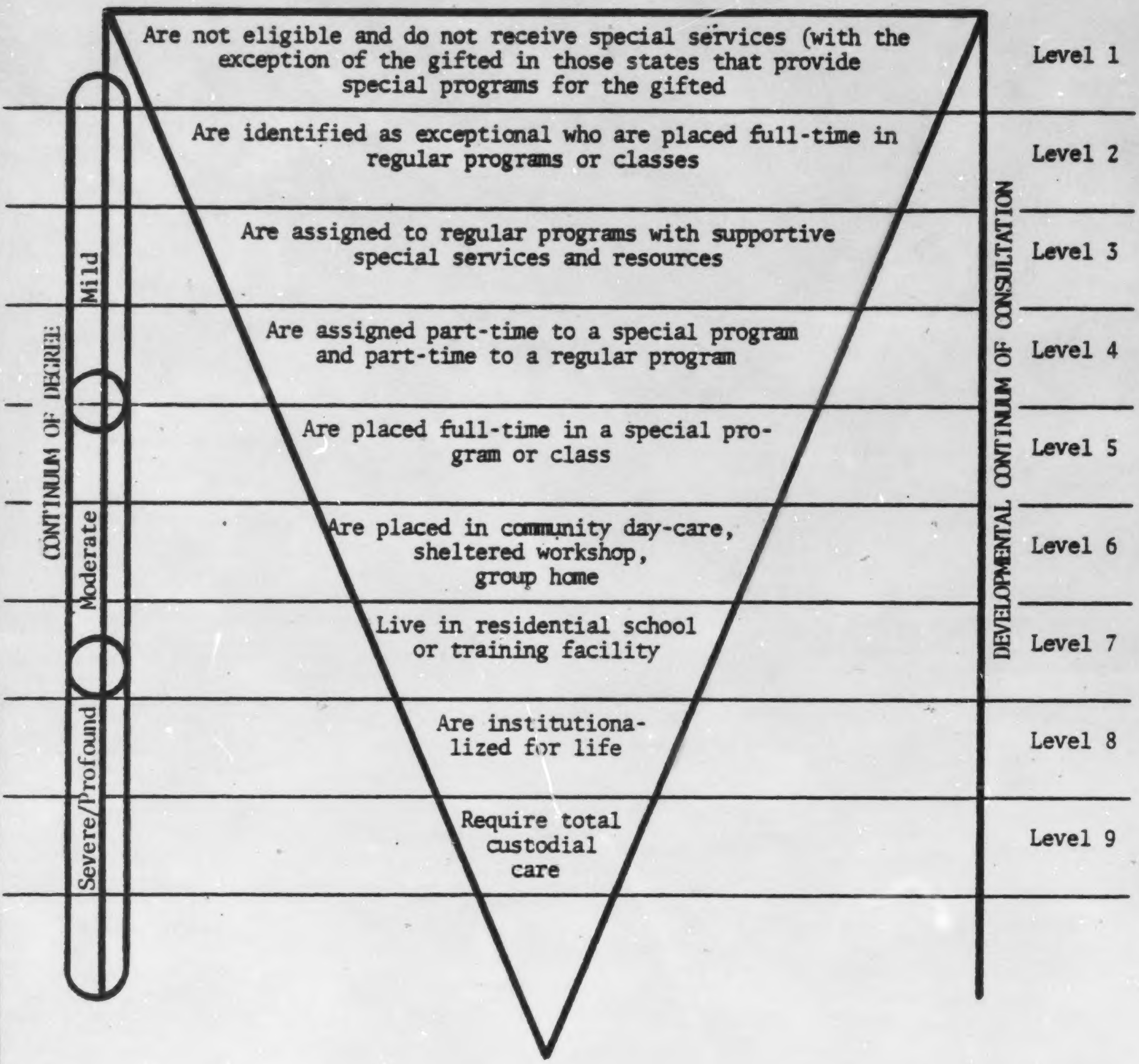
Dictates of purpose and space preclude here an intensive detailed examination of the model and its implications. A synopsis of the model and some examples of implementation will allow the reader to study it critically and judge its implications.

The number of different helping professions grows larger as one moves from the mild toward the severe/profound ranges of exceptionality. The need for consultation becomes greater as the severity and the complexity of the problems increase, and as the number of disciplines involved increases.

Level 1

At the first level of the model, most individuals and their families are not identified as eligible to receive special education services (with the possible exception of the gifted). Whether or not an individual's special needs meet the legal criteria as "exceptional," there are numerous situations that require the attention of helping professionals. Needs that stem from vocational and academic planning, testing, family disharmony, peer conflict, teen-age pregnancy, extended hospitalization, alcohol and drug abuse, and criminal activity would call several school and community professionals into play. The solutions to any of the problems that arise from these needs could involve the counselor, school psychologist, classroom teacher, principal, attendance officer, social worker, school nurse, minister, physician, or law enforcement officials. The provision of the appropriate services to an individual or family by any one of these helping professionals might require consultation with one or more other professionals. The school principal might seek consultation from the juvenile court officer to determine what legal options are available to the school administration in a case involving a pupil who has been charged with a first offense of vandalism of school property. The counselor might seek consultation from the physician in a situation involving a pregnant eighth grader.

Individuals who:


CONTINUUM OF DEGREE
Mild
Moderate
Severe/Profound
DEVELOPMENTAL CONTINUUM OF CONSULTATION

Are not eligible and do not receive special services (with the exception of the gifted in those states that provide special programs for the gifted	Level 1
Are identified as exceptional who are placed full-time in regular programs or classes	Level 2
Are assigned to regular programs with supportive special services and resources	Level 3
Are assigned part-time to a special program and part-time to a regular program	Level 4
Are placed full-time in a special program or class	Level 5
Are placed in community day-care, sheltered workshop, group home	Level 6
Live in residential school or training facility	Level 7
Are institutionalized for life	Level 8
Require total custodial care	Level 9

Figure 2. A Developmental Model of Consultation

The important distinction between consultation at Level 1 and the levels that follow is that many of the problems and needs in Level 1 do not legally qualify as exceptional. In such cases, the special educator may be precluded from providing direct services to the individual. However, existing legal guidelines do allow for consultation between any professional who is providing direct service and the special educator. This is an important and too often overlooked point. There is an understandable but unreasonable tendency to assume that any helping profession that is not directly engaged in service delivery is simply not involved at all.

On the contrary, the professional who is responsible for the direct delivery of the service (e.g., classroom teacher, counselor, social worker) to the individual should assume an open invitation to consult with any other professional whose expertise has the potential for enhancing the effectiveness of the intervention.

Levels 2 and 3

Beginning at Level 2 of the developmental model of consultation, the discipline of special education becomes more centrally engaged in the planning and provision of special services. The requirements of P.L. 94-142 (The Education for All Handicapped Children Act) must be adhered to in any case involving individuals who are identified as handicapped. Consultation between professionals is typically needed in order to properly and appropriately design a program of intervention for exceptional children that is legal, consistent, and ethically valid. Exceptional children whose special needs place them along this portion of the continuum of degree are likely to be "mainstreamed" into regular programs of intervention to the fullest extent. *Mainstreaming* is a term that has become a shibboleth to some groups and an anathema to others.

> Mainstreaming is a term used to describe the variety of administrative and organizational changes that have eliminated full-time placement in special self-contained classes for most mildly impaired children in favor of less restrictive forms of placement in the educational programs of their schools. That is, individuals with mild academic impairments are integrated, to varying degrees, into regular classes and programs in the mainstream of school life. (Wyne & O'Connor, 1979, pp. 49-50)

MacMillan (1977) has taken the position that mainstreaming must include the following elements:

1. The children are educated with children in a regular class to the maximum degree possible in light of each child's characteristics.
2. Responsibility for the child's education is *shared* by general and special education personnel--both are accountable.
3. The children are no longer classified as mentally retarded. (p. 449)

The basic assumption in mainstreaming that is of most relevance to consultation is that the mainstreamed child is a *shared responsibility*. Currently, the manner of implementing shared responsibility for the mainstreamed pupil is for each discipline to make its contribution and move on. It is up to administration and management to see that this "one-time-only" approach to consultation does not become standard operating procedure. Viewing the mainstreamed child as a shared responsibility should imply an interdisciplinary group of helping professionals with a continuing commitment to support and enhance the effectiveness of intervention through direct service and through consultation with fellow professionals who are providing direct service.

Levels 4, 5, and 6

As the nature of handicapping conditions moves from mild toward moderate on the continuum of degree, the opportunities for consultation also change. Levels 4, 5, and 6 deal with exceptional conditions that require therapeutic and medical resources, in addition to educational and psychological services. Speech therapy, physical therapy, occupational therapy, and recreational therapy are disciplines that typically serve exceptional individuals whose developmental deviations include physical, sensory, or neurological handicaps. A child with cerebral palsy whose cognitive skills permit part-time regular class participation, for example, may require the assistance of a host of different professionals both in and outside of the school setting.

Careful attention must be given to the orchestration of these professional contributions so that one resource complements, rather than limits, the effectiveness of the other resources. Efficient and effective coordination of professional resources logically demands continuing consultation among those involved. The administrative management of these resources may fall to one person (counselor or special services director), or it may be a shared responsibility. In either case, the extent to which appropriate consultation does not occur between the helping professionals accrues to the disadvantage of the child and the family.

An organizing structure in the *individualized educational program (IEP)* is required by P.L. 94-142 for every child who meets the law's criteria as exceptional (although it is equally useful for Levels 2 and 3). By law, every IEP must include the five following elements:

> 1. A statement of the child's present levels of educational performance;
> 2. A statement of annual goals, including short-term instructional objectives;
> 3. A statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular educational programs;
> 4. The projected dates for initiation of services and the anticipated duration of the services; and
> 5. Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short-term instructional objectives are being achieved.
>
> (U.S. Federal Register, August 23, 1977)

Both direct services and indirect contributions through consultation are implied by the content requirements of the IEP. Each professional--counselor, school psychologist, classroom teacher, special educator, social worker, school nurse, and administrator--is implicated at one or more points in the process: identification, referral, testing, case conference, placement, implementation, and evaluation. Appropriate involvement of the parents in the process adds still another dimension to the IEP structure. Each contributing professional has an obligation to be thoroughly familiar with the IEP process* in order to enable the helping professional to contribute directly to the design and implementation of the intervention program and to help each contributor identify points in the IEP process at which consultation with other contributors is appropriate.

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*For a comprehensive, accurate, and clear understanding of the IEP process, see Turnbull, A., Strickland, B., & Brantley, J. Developing and implementing IEPs. Columbus, Ohio: Charles E. Merrill, 1978.

Levels 7, 8, and 9

Special services for children and youth whose developmental deviations fall into the severe and profound range of the continuum may or may not directly involve public school professionals. Services to severely and profoundly handicapped persons have generally been delivered in residential settings, such as training institutions, hospitals, and clinics. Regardless of the site of delivery, exceptional individuals who require almost constant custodial care are not likely to require the services of public school personnel. However, the trend is to serve as many different types and levels of handicapping conditions as possible in the normalizing environment of the home and community, rather than in the total institution.

Levels 7 and 8 on the continuum serve exceptional persons in group homes, sheltered workshops, and developmental day care centers; this will increasingly be the case. Maximizing the appropriateness and minimizing the restrictiveness of these settings requires the combined efforts of a large number of helping professionals. This implies the need for a great deal of consultation if intervention is to be in the best interests of exceptional individuals and their families. However, placement in a residential facility is still the most common practice.

Level 9 includes exceptional individuals whose needs are almost exclusively custodial, requiring constant attention. The medical and nursing care for profoundly handicapped persons typically requires residential placement. Consultation at these levels is likely to be related to the process of *normalization.* The normalization concept originated in Scandinavian countries and means "making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society" (Nirje, 1969, p. 181). For the mildly handicapped, mainstreaming is an application of the principles of normalization. For the moderately impaired person, placement in a group home rather than total institutionalization represents normalization. In the case of severely or profoundly handicapped individuals who are residents of institutions, normalization is more difficult to accomplish. Most residential institutions have established cottage facilities that help to increase the normalcy of the environment.

Sheltered workshops and work placements within the institution can aid normalization but residents must be functioning at a certain level in order to avail themselves of these opportunities. Many types of normalization efforts, especially those that are based in the community, call for multidisciplinary action. An excellent example is the establishment of group homes for handicapped adolescents and adults. The acquisition of property, training of group home parents or counselors, work placements for group home residents, recreation, health care, and education and training require the direct and consultative services of educators, counselors, attorneys, rehabilitation counselors, therapeutic recreators, and physicians.

A related but separate clientele associated with Levels 7, 8, and 9 are the parents and families of the handicapped. The need for family and marital counseling is often a by-product of the daily pressures that handicapped individuals experience. Severe and profound handicaps place a particularly heavy burden on parents and families because of the unique and continuous attention that must be devoted to the exceptional member. The presence of a moderately or severely handicapped person in the home can produce conflict and stress that may disintegrate family and marital harmony. Unilateral attempts at intervention by any single professional, whether it be a physician, teacher, minister, or counselor are laden with risk. Communication and consultation among professionals increases the probability for successful resolution of the problems arising out of such situations.

It is important to remember that the working definition of consultation that is applied here does not involve the direct delivery of services to the exceptional person or to another professional. Consultation is a requisite and integral part of each step in the process of planning, implementing, and evaluating the delivery of services, but it should not be confused with the special service itself. This is an important distinction and runs counter to the current usage of the term "consultation" in a number of the helping professions. Some may find it useful to distinguish between types of consultation by employing descriptive labels such as cross-consultation, preventive consultation, or crisis consultation.

Attempts to label a generic and dynamic process such as consultation may have the effect of fractionalizing and categorizing, thus inhibiting rather than facilitating communication. Such labels often take on connotations that go beyond the intended meaning. Because consultation is a process, it eludes a precise definition. It can be described and circumscribed, but it can only be operationally defined by the manner and context in which it is applied. That is a part of the rationale for putting forward a model of consultation based upon a developmental view of exceptionality.

Summary

This chapter has presented an extensive discussion of the meaning of the term "consultation" to lay the groundwork for the consultation model. The model or conceptual structure classifies and organizes the theory and practice of consultation for exceptional individuals and groups. The conceptual framework was viewed as a developmental model in order to distinguish it from the traditional approach of placing exceptional persons into separate categories in order to provide them with supportive services. Several of the concepts underlying each level of the developmental model were defined, and examples were presented of how the various levels of the model can be applied.

As with any conceptual model, the ideas concerning consultation described here are intended to provoke thoughtful criticism. Neither unreflective rejection nor unreasoned acceptance of the model is consistent with its heuristic intent.

REFERENCES

Bindman, A. J. Mental health consultation: Theory and practice. *Journal of Consulting Psychology*, 1959, *23*, 473-482.

Brown, D., Wyne, M., Blackburn, J., & Powell, W. *Consultation: Strategy for improving education*. Boston: Allyn and Bacon, 1979.

Caplan, G. *Dynamics of mental health consultation*. Unpublished manuscript, Harvard University, School of Public Health, 1954a.

Caplan, G. *Principles of mental health consultation*. Unpublished manuscript, Harvard University, School of Public Health, 1954b.

Caplan, G. Mental health consultation in the schools. In *The elements of a community mental health program*. New York: Milbank Memorial Fund, 1956.

Caplan, G. *Concepts of mental health and consultation*. Washington, D. C.: Children's Bureau, 1959.

Caplan, G. *The theory and practice of mental health consultation*. New York: Basic Books, Inc., 1970.

Federal Register, U. S. Government Printing Office, Washington, D. C., August 23, 1977.

Gallagher, J. J. The special education contract for mildly handicapped children. *Exceptional Children*, 1972, *38*, 527-535.

Lewis, J. A., & Lewis, M. D. *Community counseling: A human services approach*. New York: John Wiley & Sons, 1977.

MacMillan, D. L. *Mental retardation in school and society*. Boston: Little, Brown, 1977.

Nirje, B. The normalization principle and its human management implications. In R. Kugel & W. Wolfensberger (Eds.), *Changing patterns in residential services for the mentally retarded*, pp. 179-188. Washington, D. C.: President's Committee on Mental Retardation, 1969.

Wyne, M. D. Consultants and exceptional children. In D. Brown et al., *Consultation: Strategy for improving education*. Boston: Allyn and Bacon, 1979.

Wyne, M. D., & O'Connor, P. D. *Exceptional children: A developmental view*. Lexington, MA: D. C. Heath and Company, 1979.